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THE BUDGETARY IMPACT OF RISING HEALTH CARE COSTS

HEARINGS

BEFORE THE

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

AUGUST 28, 1985—MEMPHIS, TN
AUGUST 30, 1985—NASHVILLE, TN

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THE BUDGETARY IMPACT OF RISING HEALTH CARE COSTS

WEDNESDAY, AUGUST 28, 1985

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Memphis, TN.

The committee met, pursuant to notice, at 2:30 p.m., at the Adams Pavilion Medical Center, Memphis, TN, Hon. Jim Sasser presiding.

Present: Senator Sasser.

Staff present: Lance Simmens, legislative assistant.

OPENING STATEMENT OF SENATOR SASSER

Senator SASSER. I'll call these proceedings to order here today. First, let me say that we're holding these hearings under the auspices of the Budget Committee of the U.S. Senate to look into a matter that I think is of great concern to us all. And that is the health and longevity of our Medicare system.

The issue of rising health care costs is one of the most critical issues facing the Congress this year and one that will be facing us. I fear, for many years to come, particularly in light of the very large budget deficits that our Federal Government is running.

MEDICARE TRUST FUND FACING DEPLETION

Now, let me state right off the bat, under present policies and using standard economic projections, the Medicare Trust Fund will be deplected by the end of this century. This threatens the Federal Government's Hospitalization Insurance Program for the elderly.

Chart 1 shows trust fund balances for the next 15 years. As you can see, by 1998 the Medicare Trust Fund will no longer be sufficient to meet the needs of Medicare beneficiaries.

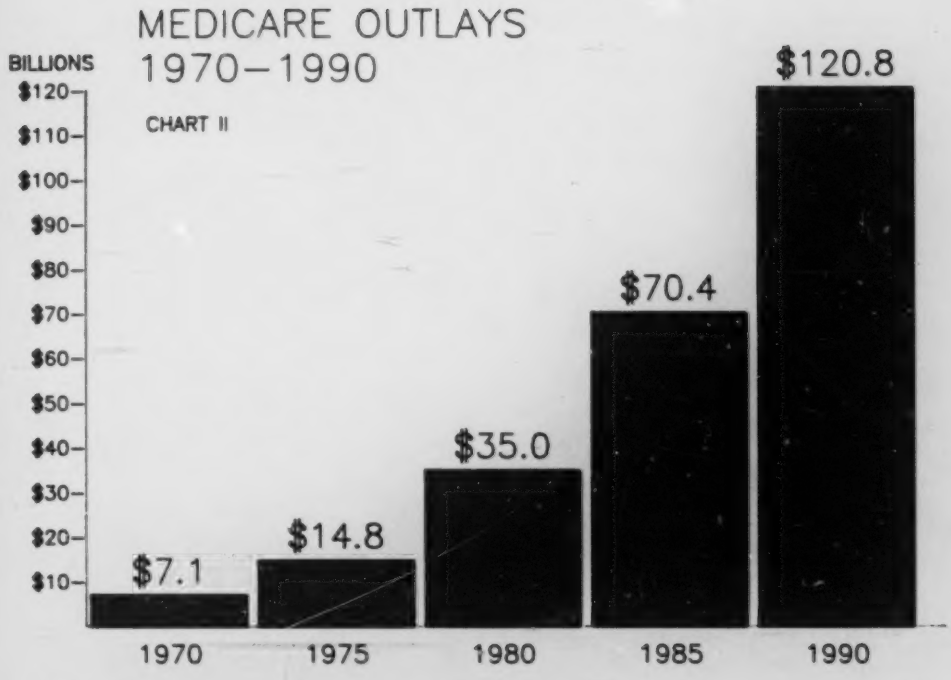
FINANCIAL HEALTH OF MEDICARE FUND

As a member of the Senate Budget Committee, I've been actively involved in efforts to significantly reduce the large impending budget deficits which will approach or exceed $200 billion, I'm sorry to say, for the next few years. Deficits of this magnitude pose a grave threat to our economy in and of themselves. But, they also contribute to increased pressures on Congress to reduce essential domestic spending programs such as Medicare.

Recent congressional debate on the budget resolution clearly illustrated the confusion that exists over whether to include Social Security and Medicare in a deficit reduction strategy. Many of us steadfastly refused efforts to do that because Medicare and Social Security are trust funds that are composed of employee and employer contributions and they neither contribute to the deficit nor cause it. These trust funds are self-supporting. As a matter of fact, one of them, the Old Age and Survivors Trust Fund of Social Security is now building up a healthy surplus.

MEDICARE BENEFITS DOUBLE EVERY 5 YEARS

Chart 2 illustrates that Medicare benefits have approximately doubled every 5 years since 1970. Now, these are the benefits that the Medicare system has been paying out since 1970. And as you can see, in 1970 expenditures were $7 billion. By 1975 they had gone up to $14.8 billion, roughly doubling the benefits being paid out in 5 years. And that pattern continues and is projected to continue until 1990. From 1980 to 1985 it increased from $35 billion to $70 billion, roughly doubling. From 1985 to 1990 it's projected to increase from $70 billion to almost $121 billion, still continuing to roughly double the amount of benefits paid out in a 5-year period.



The Medicare Program is celebrating its 20th anniversary this year. It provides a nationwide system of health insurance coverage for individuals who are 65 years of age or older. Suffice it to say, the Medicare Program has been an enormous success from the point of view of medical treatment, from the point of view of giving our aging population the medical care to which it's entitled. And the program, while it's been a large success, has had a problem with inflation in the health care industry. This, taken in conjunction with a rapid aging of the general population, leads us to believe there will be serious problems with the program before the end of the century.

As most people in this room know, the cost of quality health care continues to rise at an astonishing rate. In 1983, the Department of Health and Human Services of the U.S. Government estimates that $355 billion was spent on health care costs in this country. This averages out to over $1,500 for every man, woman, and child in the population of the United States.

HEALTH CARE COSTS EXCEED CPI

Now, over the past 20 years increases in the cost of health care services have exceeded price increases in the rest of the economy by a significant amount. Chart 3 shows real growth. When I say real growth, I refer to the spending for health care costs corrected for inflation as measured by the Consumer Price Index beginning in 1965 and continuing through 1984. In every one of these years you can see that health care costs have been exceeding the Consumer Price Index very substantially from 9.2 percent in 1972 down to a low of 1.8 percent in 1980 and then jumping back up by

1982 to where health care costs were exceeding the CPI by 6.5 percent and on and on. Over the long term, health care costs have been exceeding the rate of inflation by about 50 percent.

REAL GROWTH IN HEALTH COSTS
1965 – 1985 CHART III

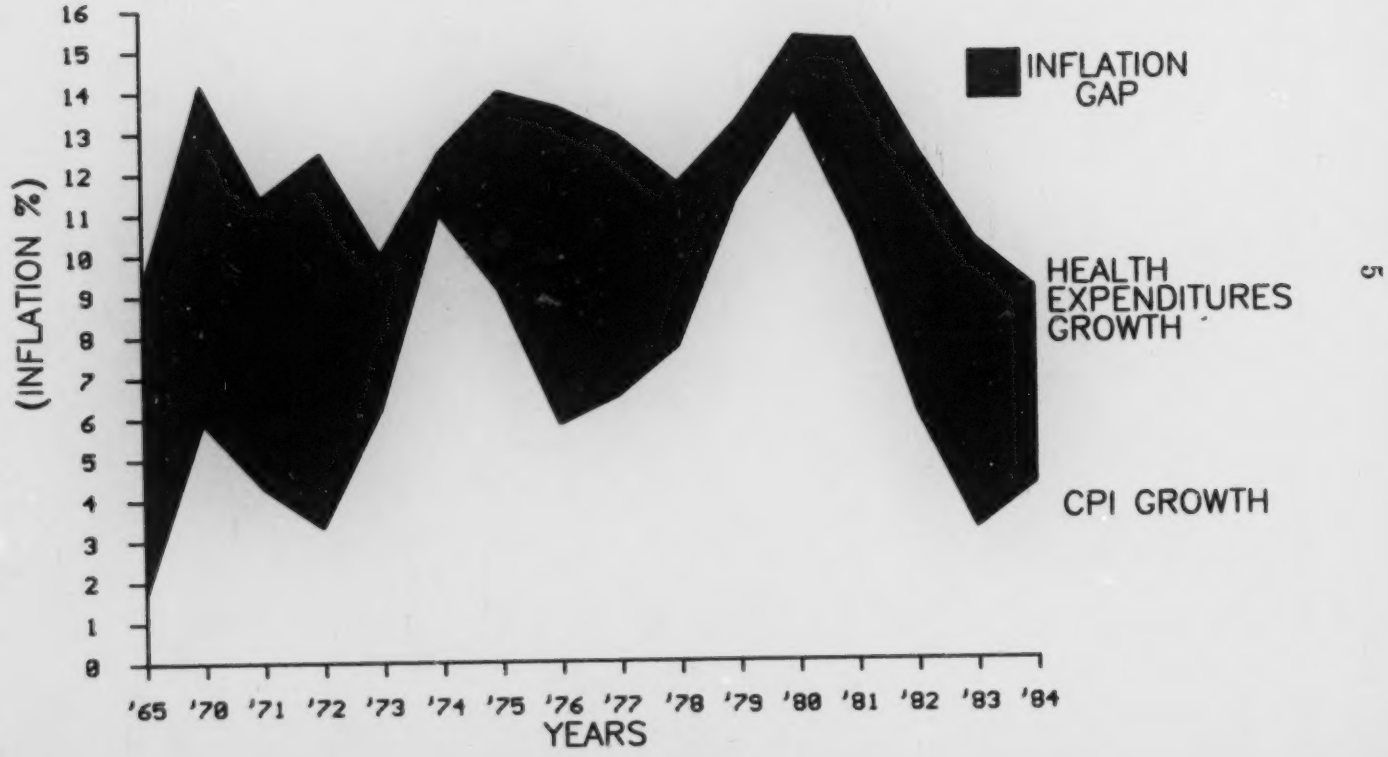


TABLE I TO ACCOMPANY CHART III.

The following table is intended to further clarify Chart III. The darkened area in Chart III reflects the inflation gap between the rate of inflation in the general economy and inflation in health expenditures in selected years 1970 through 1984. Also, figures for 1965 are used for purposes of reference to a particular starting point.

YEAR	CPI (%)	HEALTH COST INFLATION (%)	DIFFERENCE (%) (inflation gap)
1965	1.7	9.3	7.6
1970	5.9	14.2	8.3
1971	4.3	11.4	7.1
1972	3.3	12.5	9.2
1973	6.2	10.0	3.8
1974	11.0	12.5	1.5
1975	9.1	14.0	4.9
1976	5.8	13.6	7.8
1977	6.5	12.9	6.4
1978	7.7	11.7	4.0
1979	11.3	13.2	1.9
1980	13.5	15.3	1.8
1981	10.4	15.2	4.8
1982	6.1	12.6	6.5
1983	3.2	10.3	7.1
1984	4.3	9.1	4.8

As this chart clearly shows, the gap between health care inflation and the Consumer Price Index has continued to grow fairly steadily since 1980. Well, we must undertake, I think, a cooperative approach to try to curb the rate of increase and narrow the disparity between the inflation in health care costs and inflation in the economy as a whole.

The American Hospital Association compiles detailed measures on the expenses in our Nation's community hospitals.

HOSPITAL COSTS INCREASING

In its latest survey, the American Hospital Association provides dramatic evidence of the increased expenses that the hospitals themselves have incurred in trying to provide quality health care. Total community hospital expenses in 1983 amounted to $120 billion. Now, this $120 billion in direct hospital expenses represents an increase of 452 percent over a 10-year period measured from 1973. At the same time the average cost of a day in the hospital in 1983 was $391 and this represents a 372-percent increase from 1973 or over the same 10-year period.

So, while hospital expenses were increasing by 452 percent, the cost of the patient for a day in the hospital was increasing at a rate of 372 percent. So, you can see that the hospitals are partially absorbing some of the cost of their increased expenses. Now, there are a number of factors I think which contribute to these increases, but it's not the purpose of this hearing here today to cast blame on any one sector of the health care industry. The purpose today is to face realities and try to gather information and use this information to devise effective and hopefully cost-efficient remedies to these problems yet still will meet the needs of our elderly citizens for quality health care.

COOPERATIVE EFFORT NEEDED

I think it's an enormous job. We must all work together, doctors, physicians, hospitals, beneficiaries and others in a cooperative effort to locate the problems and address them. This hearing is really just a beginning. We want to begin work in the Senate before the actuarial crisis that's emerging in Medicare is upon us and responsible budetary policy I think dictates that this be done. And also I think a fundamental sense of compassion and fairness for our elderly citizens demands that this be done.

We are going to hear from citizens of this city today, from beneficiaries, from health care providers and from others. Our first panel of witnesses today will represent Medicare beneficiaries who have had direct and firsthand experience with the Medicare system. I'll ask Mr. Otis Elder and Mr. and Mrs. Abe Lapides to come up to the witness table if you would please, and we'd like to get the benefit of your views. And I want to thank you for appearing here today.

Mr. Elder, if you would begin and perhaps Mrs. Lapides could slip that microphone over in your direction and we'll get underway. You just sit there and talk into the microphone, Mr. Elder, and what you say, your experiences, are being taken down by this young lady over here and this will be transcribed and then it will

be reviewed by those of us in Washington who are trying to come up with some solutions to our problems with the Medicare system. So, you just relax and tell us what's on your mind and we may have a question or two for you.

STATEMENT OF OTIS ELDER, MEDICARE BENEFICIARY

Mr. ELDER. Well, Senator, I was raised and born right here in Memphis, TN. I'm 75 years old now. And my experiences with the hospital is the first time I ever been in the hospital in my life was about, you know, in February I think it was. I went to the hospital on my leg here. Of course, the doctors took and worked, did all kinds of working around my leg, gave me different places, you know, on my leg. This last they started working on my leg with such stuff as Benadine mostly. I don't take to—they gave me the pills in the hospital. I've been taking pills outside the hospital and I just can't cut that—them big $450 pills at the time.

COST OF PILLS FOR LEG HIGH

Every time I go to the drugstore I have to pay about $35 or $40, $50 for pills and things for, you know, different pills on my leg and everything. I just—when I went in the hospital I went in there—I forgot what date it was I went in there but I stayed in the hospital about a week in intensive care. I had an emergency. My son and them carried me over there one day about 12 o'clock. After they looked at my leg they kept me in the hospital. So, I stayed in there about, I reckon about 15 days.

And when I took—left—stayed in the hospital they give me every kind of test that could be tested out, my heart and my kidneys, my everything. And I figured I was all right but they just started working on my leg with this Benadine. It seemed to be all right. But, now my leg is coming right back down on me again.

PROBLEM WITH LEG NOT REVEALED

Senator SASSER. Did the doctors or the physicians make a diagnosis or tell you what the problem was with your leg?

Mr. ELDER. No, they never did tell me what the problem was with my leg. All they did was just work on my leg, try to get my swollen foot down, see. When my foot swelled up—these are some shoes which I bought later. I couldn't wear shoes when I started getting unnerved because after I took and went into the hospital they took—the hospital bill, 2 weeks——

TREATMENT NOT POSSIBLE WITHOUT MEDICARE

Senator SASSER [interposing]. Let me ask you some questions, Mr. Elder. The question I want to ask you is this, without Medicare, could you have afforded to pay for the treatment on your leg?

Mr. ELDER. No, sir.

Senator SASSER. All right. Now, how much was your hospital bill?

Mr. ELDER. My hospital bill was $10,000 for 2 weeks, a little over 2 weeks.

Senator SASSER. A $10,000 hospital bill for 2 weeks?

Mr. ELDER. Plus what I'm paying, I've got to pay two doctors, one coming up for surgery and the other one, he just came in there. And the other doctor, the one that waited on me, when he finally turned me loose, said I didn't have no operation or nothing, it was about another week when the other doctor turned me loose and sent me home.

MONTHLY INCOME LESS THAN $300

Senator SASSER. Would you tell the committee, Mr. Elder, what is your monthly income?

Mr. ELDER. My monthly income, I was self-employed. I was retired. I worked for the Commercial Appeal.

Senator SASSER. Do you work for the Commercial Appeal?

Mr. ELDER. Yes.

Senator SASSER. Did they have a very good pension plan? You don't have to answer.

Mr. ELDER. No, I wasn't there long enough to be on the pension plan. I've been self-employed. When I first started I worked at Fisher Butter Plant (phonetically). Later on I started working for myself.

Senator SASSER. Tell us what your monthly income is now?

Mr. ELDER. Is less than $300.

Senator SASSER. Less than $300?

Mr. ELDER. Yes.

Senator SASSER. Slightly under $300? Would that be a fair——

Mr. ELDER [interposing]. $291.

Senator SASSER. $291?

Mr. ELDER. Yes.

Senator SASSER. And do you have any other income?

Mr. ELDER. No more than my wife. She is sick too. My wife, she is just like I am. I've got to pay—otherwise I was paying these doctors, trying to ease them out—my daughter is—told me how to pay the bills. I paid—the hospital bill was around $400 something. Each one of them doctors was around $300 and something. And then I had something. It was around $300.

AMOUNT OWED FOR MEDICAL BILLS

Senator SASSER. All right. How much do you presently owe in outstanding bills for treatment for your medical condition?

Mr. ELDER. I don't exactly know because I ain't paid but two or three times, you know, by the month. That's taken up all my money plus what I'm paying, getting the pills and things.

Senator SASSER. Can you give the committee a rough estimate of how much you presently owe?

Mr. ELDER. How much what?

Senator SASSER. How much you presently owe by the way of medical bills.

Mr. ELDER. When Medicare deducted it down, see I owed—they paid, in front they paid $10,000, the Medicare did, and then they paid—they must have paid one of them doctors some of the money.

Senator SASSER. My staff tells me you owe about $1,000.

Mr. ELDER. It's about $800 I think. Of course, I owe $100 or $200 and something and the other $200—about four different doctors and things.

UNABLE TO PAY MEDICAL BILLS ON PRESENT INCOME

Senator SASSER. Now, on your income, Mr. Elder, the question is can you afford to pay these medical bills?

Mr. ELDER. No. That's the reason I came up here.

Senator SASSER. That's the reason you came up here?

Mr. ELDER. Yes.

Senator SASSER. And you're presently taking medicine; is that correct?

Mr. ELDER. Yes. I'm taking medicine right now.

Senator SASSER. Can you afford on your income to buy the medicine?

Mr. ELDER. See, I got my wife there. Our income is together, you know. Her income and mine is together. That's what keeps us kind of going. I can't even get out there and do no work at all.

Senator SASSER. Well, thank you, Mr. Elder. The purpose of your testimony today is to indicate to us for the record that you are unable to meet the deductible portions of the Medicare Program and that given your income and many like yourself who are on minimum Social Security payments, that they simply cannot meet the threshold payments or the payments that are required of them even under the present Medicare Program that we have.

We'll turn now to Mr. and Mrs. Lapides. I want to welcome both of you here today and express my appreciation to you for coming and giving us the benefit of your experiences and the benefit of your testimony.

And as I understand it, Mrs. Lapides, you're going to be the spokesperson here today for your husband who is the one who suffered the physical problem.

STATEMENT OF MRS. ABE LAPIDES, MEDICARE BENEFICIARY

Mrs. LAPIDES. Well, we have quite a different problem from Mr. Elder obviously. We're not indigent. We are in the group of the greatest majority of people in the United States; we're low-middle income. And we are very dependent on Medicare. Now, our questions and our fears of the future, what's going to happen and how we are going to get help, because as I understand it, the rules and regulations of Medicare at this point restrict various and sundry cases of people going into the hospital. My husband is a victim of—first of all, I'll tell you I'm a cardiac cripple, unable to have the surgery.

My husband was a victim of cancer 7½ years ago. Twice a year—just like President Reagan.

Senator SASSER. Colon cancer.

Mrs. LAPIDES. Colon, uh-huh. Unfortunately, my husband's invaded the colon walls. This will be the first time that he's hearing this, but he did have a very bad type and it did get into the lymph nodes.

Senator SASSER. He looks remarkably healthy.

Mrs. LAPIDES. He's survived.

Mr. LAPIDES. She's taken good care of me.

HOSPITAL ADMITTANCE UNDER MEDICARE IS A PROBLEM

Mrs. LAPIDES. It's been with God's help. But anyway, what I'm concerned about now is the future and how do we get into the hospital on Medicare. We no longer have hospitalization. We were told by insurance people that Medicare and a supplemental policy would take care of our needs and that's what we have. That's what the vast majority of American people do I believe, people in our income group.

My husband's gastroenterologist was very concerned about his going to the hospital twice a year for a procedure called a colonoscope. He did not want to put—he did not want to do the colonoscope on an outpatient basis. He wanted to do it with my husband in the hospital the day before the procedure, because it's a very nasty, very weary, very difficult procedure. You have to fast for 2 days before the actual colonoscope. And then besides that, on the second day it's a very difficult procedure to clean the patient out. Our gastroenterologist would not think of putting him into the hospital—would not think of doing the colonoscope without entering him into the hospital the day before so that he could be professionally cleaned out.

This time our appointment is in about a week and our gastroenterologist suddenly tells me you can't go into the hospital for it, it's going to have to be done on an outpatient basis. My husband——

Senator SASSER [interposing]. This is because Medicare coverage will not do it, carrying out this procedure in the hospital?

Mrs. LAPIDES. That's right.

MEDICARE COVERAGE HAS BEEN NARROWED

Senator SASSER. Because the coverage, as I understand it, has been narrowed to the point that your husband would not qualify for this being done in the hospital.

Mrs. LAPIDES. In the hospital, that's right. Unfortunately—he looks a lot healthier than he is. He cannot do this by himself. And frankly, I'm not really in physical condition to be of great help to him. It also means that he's going to have to take an added day off from work, which is an expense to us. We would be better off with private insurance than Medicare. What frightens me—first of all, I was frightened when I walked in the door.

Second of all, when I got through looking at your charts I really got frightened and now I'm wondering how are people on our income level, how are we going to get the proper medical help with Medicare. We can't afford to take care of ourselves. The supplemental policy does not pay unless Medicare pays. So, now we're stuck.

Senator SASSER. Let me ask you some questions, Mrs. Lapides, if I may in order to make it clear for the record what we're attempting to demonstrate here. Now, it's true that Medicare used to cover treatment for your husband's illness entirely on an in-patient basis, that is he could go to the hospital and have the treatment, particularly the sort of preparatory treatment you just described for us now.

Mrs. LAPIDES. Yes.

Senator SASSER. But, because of recent changes in the Medicare rules your husband will now have to be treated on an out-patient basis.

Mrs. LAPIDES. That's right.

HARDSHIPS BEING PLACED ON OLDER PEOPLE

Senator SASSER. The Medicare coverage will not pay for him undergoing the preparatory treatment for this procedure to be carried out. He has to do that on an out-patient basis. Now, the question is, What kind of hardship does this place on you and your husband? You've indicated that you have a cardiac condition I think.

Mrs. LAPIDES. Physical or mental?

Senator SASSER. Both.

Mrs. LAPIDES. I'm only speaking of physical. It places a great deal of hardship on us. I would hate to have to go into detail. There are doctors in the room. I'm sure they understand. It is a very weakening procedure. It's a very difficult procedure and especially if you're dealing with someone in the seventies, in other words anyone over 65 and over who gets this type of—the average person who has their own insurance will go into the hospital for this.

Senator SASSER. Do you feel that the current Medicare system is delivering the type of treatment that's necessary for your husband's ailment in the manner in which it should be delivered?

Mrs. LAPIDES. I'm not quite sure that I'm clear with what you've just asked me. I do feel that you can't have a blanked rule and say this applies to everyone. Some people, for instance I know, are being—having operations in the hospital and being put out of the hospital as fast as possible because of the Medicare financial situation. Some of those people have no one to go home to to take care of them. The same thing practically applies backwards here. My husband does need this last minute procedural help.

HUSBAND DEPRIVED OF SOME MEDICAL PROCEDURES

Senator SASSER. But, the Medicare rule changes, as I understand it, that have gone into effect recently you feel have deprived your husband of some of the medical procedures or medical treatment that would be beneficial to him?

Mrs. LAPIDES. Yes, I do. In other words, why would my gastroenterologist or our gastroenterologist refuse to do this on an out-patient basis before and now suddenly he can't go into the hospital. I'll tell you very frankly I'd like for my husband to speak to this. It's a very weakening procedure. It really drains the system. It takes a strong, young, healthy person to go through this. He's neither young, strong nor healthy. I'm unfortunately not in very good condition to help him too much.

Senator SASSER. What is your husband's age?

Mrs. LAPIDES. Seventy-one, shortly seventy-two.

Senator SASSER. Well, I want to thank you, Mrs. Lapides.

Mrs. LAPIDES. Would you like to speak to my husband?

Senator SASSER. If he has anything to add we would be delighted to hear from him.

PROCEDURE PRECEDING COLONSCOPE TAXING AND DIFFICULT

Mr. LAPIDES. I think Mildred covered the situation quite adequately. It's the procedure preceding the colonscope that is taxing and difficult.

Senator SASSER. You feel that given your present condition this procedure should be carried out in a hospital on an in-patient basis rather than an out-patient basis?

Mr. LAPIDES. I think so. We're seeing yearly the lessening of the Medicare care, the care that Medicare provides, let me put it that way. Each year that we go through this procedure it's costing us more and more every year. And as Mildred said before, we're concerned for the future and not as much for the present. I think that she has stated everything quite nicely and adequately and I hope it's suitable for your purposes.

Senator SASSER. I think it is, Mr. Lapides. I think you've demonstrated there is a narrowing of coverage and how it's impacting on you with your present illness.

Mrs. LAPIDES. Senator, I'm mostly concerned the great majority of Americans who will encounter situations such as this. I don't think everybody can be put into the same category. Some people feel better than others; some people are more healthy than others. I don't think you can be lumped into a group like that. But, I am frightened for the future. I think when the impact of all of this hits the great majority, there's going to be some problems.

MEDICARE RULES NOT SENSITIVE TO PARTICULAR NEEDS

Senator SASSER. I think what your testimony demonstrates today, Mr. and Mrs. Lapides, is that Medicare rules are not sensitive in many cases to the particular needs of a particular patient's condition. What we're seeing now is, I think, a broad stroke reduction of coverage and it's having the result of applying to everybody across the board and not giving in many cases the treating physician or the Medicare recipient the latitude to exercise their judgment on what type of treatment might be covered. We simply have one broad rule and there's no deviation.

Mrs. LAPIDES. Senator, may I take one moment out of your time, Senator?

Senator SASSER. Yes.

Mrs. LAPIDES. I understand there is a review board where the doctor can appeal and go before the review board. It takes about 5 days or more to get before the review board. And I want to tell you, I don't know any doctors, I don't know any at all who will spend all of their time before a review board.

Senator SASSER. I don't know of any either that will do that. Well, I want to thank you, Mr. and Mrs. Lapides, for appearing here today and giving us the benefit of your views and also you, Mr. Elder, thank you very much.

Our next panel of witnesses will consist of representatives of the home health care industry. Mr. Russell Vizzi is presently president and executive director of the Mid-South Comprehensive Health Care and Hospice Agency. If you would come forward, Mr. Vizzi. This is a nonprofit agency which serves six counties in Tennessee and five counties in north Mississippi.

Mr. Vizzi is a member of numerous professional associations and is chairman of the Medicare Liaison Committee of the Tennessee Association of Home Health Care. I might say that Mr. Vizzi received his bachelor's degree in industrial engineering from Farleigh Dickinson University and a master's degree in industrial management from Stevens Institute of Technology. He'll be joined by Ms. Cathey Stitt. If you would come forward, Ms. Stitt.

She is currently the executive director of the Visiting Nurses Association of Memphis. Previously Ms. Stitt worked with the Visiting Nurses Association of Detroit, MI, and she has taught nursing and community health and received her degree from the Medical College of Georgia in 1970, and a master's degree in nursing from the University of Colorado in 1974.

She's a member of numerous professional associations including the American Nurses Association. We look forward to hearing your testimony today and we'll start with you, Mr. Vizzi.

STATEMENT OF RUSSELL F. VIZZI, DIRECTOR, MID-SOUTH COMPREHENSIVE HOME HEALTH AND HOSPICE, MEMPHIS, TN

Mr. VIZZI. Thank you. Senator Sasser, I understand the reason you're holding these hearings today is to take a look at some of the problems facing the Medicare system.

Senator SASSER. Correct.

Mr. VIZZI. In light of the financial difficulties facing the Medicare Trust Fund over the next 10 to 15 years, it seems absolutely incredible to me that an issue as important as home health care, a viable alternative to institutionalization, should be permitted to be so narrowly neglected in the current debate of efforts to curb escalating home health costs.

HOME HEALTH CARE IS EFFECTIVE ALTERNATIVE TO INSTITUTIONALIZATION

At a time of increasing concern about the expenditure of Federal money on health services, home health care is a humane and effective, very cost-effective, alternative to institutionalization for the elderly and the disabled American. The home health benefit is inevitably growing as the population ages; as technology advances; as home health agencies themselves develop the procedures to fight against more complex cases; as more patients and as more physicians become aware of its benefits; and as Federal policies, such as the prospective payment for hospital, encourage the use of noninstitutional care.

Clearly, the elderly of this country desire expanded home health services. In a recent Gallup poll conducted by the American Association for Retired Persons, home care was preferred to institutional care by about 80 percent of the AARP's membership.

HOME HEALTH CARE PARADOXICALLY CITED

Despite strong congressional and public support, we find the greater use of home health care paradoxically cited as justification by the Health Care Financing Administration, HCFA, for developing excessively stringent regulations and policies to govern the home health program. We believe that it makes no sense to pursue

policies which encourage deinstitutionalization while hindering the ability of home health agencies to deliver medically necessary services to patients upon discharge. We believe HCFA's actions are in direct contradiction to Congress' historic action to increase access to health care.

As a result of restrictive reimbursement policies developed years ago by HCFA, the skilled nursing benefit is no longer available to many Medicare beneficiaries in need of nursing home care. Now HCFA has developed a series of policies to realize shortsighted savings in the home health benefit, which will ironically only lead to higher institutionalized costs down the road for those patients who should receive less costly home health care.

Over the last 2 years we have witnessed a series of actions on the part of HCFA which will reduce the ability of home health agencies to actually deliver services to elderly and disabled Americans. Acting with little or no consultation with the affected providers and consumers, HCFA has, one, proposed regulations which would have the effect of eliminating the waiver of liability protection from home health agencies; two, acted to reduce fiscal intermediaries serving freestanding home health providers from 47 to 10; implemented new home health cost limits; sought imposition of a $4.80 copayment for all home health visits after the 20th visit; and attempted to change the rules to redefine homebound and intermittent in order to restrict the availability of home health services; and currently they have and are developing a new minimum data element reporting requirements for all home health agencies. It's massive forms that we have to contend with today.

HOME HEALTH COST LIMITS

Now, I am submitting a full written statement for the record.[1] However, due to the time limitations I will confine my specific comments to the recently imposed home health cost limits because I think it's really very important for us. On July 5, 1985, HCFA published in the Federal Register a notice retroactive to July 1, 1985, which basically abandons the current methodology for calculating cost limits for reimbursement for home health agencies.

For the past 5 years home health agencies have operated under a system which sets the reimbursement limit on each visit at the 75th percentile of the overall national agency costs. The fact that the rates are currently calculated in the aggregate allows an agency the flexibility to provide certain kinds of care which exceed the cost limit cap. High cost services, for instance physical therapy, and the cost of providing free care to indigent patients are offset by being under the limit in other services. The ability to aggregate allows an agency to stay beneath the cost limit overall, while providing a full integrated range of care.

PROPOSAL WILL DECREASE QUANTITY OF SERVICES

Legislation, S. 1450/H.R. 3202, has been introduced which will nullify this new methodology. Without congressional intervention we fear the result of this proposal will decrease the quantity of

[1] See p. 22.

services available, but also will jeopardize the quality of care rendered to the elderly and disabled beneficiaries.

I'd like to take a few moments to tell you what the effect of this regulation will have industrywide. First, the level of home care services which Congress have mandated by statute for Medicare beneficiaries will be significantly reduced at a time when the demand for such services is sharply increasing. The reason for the increase is the enactment of a prospective payment system, DRG's, for hospitals which creates the incentive to move patients from hospitals to the home care setting.

Second, agencies will no longer offer important but costly services, such as physical therapy, for which they will not adequately be reimbursed.

Third, agencies in the rural areas will be devastated. Such agencies have significantly higher costs as they try to deliver services. Obviously transportation expenses are much higher in those areas. And also, you know, the employees must go a greater distance to reach their patients. In addition, therapists and other social workers are often scarce and therefore more costly in the rural areas. This will increase the per visit length and cost.

IMPOSSIBLE FOR PUBLIC HEALTH SERVICE TO DELIVER SERVICES

The policy of undermining rural home health agencies puts the Federal Government in the incongrous position of spending millions of dollars in grants and loans to help create such agencies with one program—and I'm referring here to the Public Health Service—and making it virtually impossible for them to deliver the services to clients through another program, our own Medicare Program.

Fourth, agencies will drop out of Medicare. We expect hundreds of agencies will in fact go bankrupt.

Fifth, the level of paperwork required by the new system will increase dramatically leading to higher Medicare costs; ironically such costs will have absolutely no relation to the provision of medical care.

Sixth, agencies which provide so-called high-tech care, such as the care of ventilator-dependent persons, IV chemotherapy or IV nutritional therapy will find it increasingly harder to do so. These services have relatively high costs and will be discouraged under the new reimbursement system. Ironically, these are among the very services which makes it possible to move patients from hospitals into the less intensive settings.

And seventh, agencies will be forced to be selective about which Medicare patients they will take. Agencies may be reluctant to take the so-called heavy care patients, such as stroke victims whose costs per case is relatively high and, of course, indigents. Agencies may well become selective in the distance they will have to travel to get to those patients and to deliver care.

And eighth, new agencies and small agencies will be hardest hit, regardless of how efficient they are. These agencies tend to have relatively higher costs and will be at an economic disadvantage. Older agencies will suffer to the extent that they have tenured employees and therefore higher paid staff. The incentive, of course,

will be to try to replace some of those with the possibility that quality may suffer.

And ninth, significantly the proposal would either eliminate or sharply reduce care. The Visiting Nurse Services of New York City, for example, gave $2½ million of free care to indigents last year. The money was raised through private contributions. Such contributions will be needed to compensate the agency for the Medicare losses in the future.

FREEZE MANDATED IN MANY SECTORS OF HEALTH CARE

In our own Memphis area we are faced with publicly announced hospital cutbacks in indigent care. Many of us look to the private sector for contributions in order to fund delivery of charitable care. A recent freeze, as we all know, has been mandated in many sectors of health care. The home health industry stated its willingness to accept a freeze as of the June 30, 1985, level. Unfortunately, the home health industry was not considered in the legislative freeze. Worse, it was subjected to these administrative cutbacks that I've already described.

FORBID IMPLEMENTATION OF NEW COST LIMITS

In conclusion and in light of the problems that I have discussed here, we urge the Congress to take the following actions:

One, Congress should enact legislation, S.1450/H.R. 3202, to forbid the implementation of the new cost limits during the period of any freeze on Medicare provider reimbursement.

Senator SASSER. You know, we introduced legislation to do that and I'm a cosponsor.

Mr. VIZZI. Yes, congratulations to you, sir. We thank you, sir. Two, Congress should direct HCFA to fully withdraw the proposal to eliminate the presumption of waiver liability. And three, Congress should enact legislation to statutorily define intermittent care—these are bills S. 778 and H.R. 2371—as soon as possible. These actions will go far in protecting the Medicare beneficiary's right and access to home care.

I want to take these few moments to commend this committee for holding this important hearing and for recognizing that there are significant problems with the administration of home health benefit under the Medicare Program. I thank you, Senator Sasser and members of this committee, for the opportunity to appear here today and would be pleased to answer any questions.

Senator SASSER. Thank you, Mr. Vizzi.

[The prepared statement of Mr. Vizzi follows:]

TESTIMONY OF

RUSSELL F. VIZZI

Director

Mid-South Comprehensive Home Health & Hospice

Memphis, Tennessee

Mr. Chairman and Members of the Committee: My name is Russell Vizzi, I am the Executive Director of Mid-South Comprehensive Home Health & Hospice located here in Memphis. I serve on the Board of Directors of the National Association for Home Care (NAHC). NAHC is the nation's largest organization representing home care and Hospice providers, with approximately 3,000 members.

I am also on the Board of Directors of the State of Mississippi Home Health Association and Chairman of the Medicare Liaison Committee, Tennessee Association for Home Health.

I would first like to commend this Committee for holding this important hearing and for recognizing that there are significant problems with the administration of the home health benefit under the Medicare program. I appreciate the opportunity to appear here today to discuss the impact of recent regulatory changes which dramatically affect the ability of HHA's to provide home care services to the nation's elderly.

At a time of increasing concern about the expenditure of Federal money on health services, home health care is a humane and cost-effective alternative to institutionalization for elderly and disabled Americans. The home health benefit is inevitably growing as the population ages; as technology advances and home health agencies develop the ability to care for more and more complex cases; as more patients and physicians become aware of its benefits; and as Federal policies, such as prospective payment for hospitals, encourage the use of non-institutional services. Clearly, the elderly of this country desire expanded home care services. In a recent Gallup Poll conducted for The American Association for Retired Persons, home care was preferred to institutional care by about 80 percent of AARP's membership.

Despite strong Congressional and public support, we find the greater use of home care services cited as justification by the Health Care Financing Administration (HCFA) for developing excessively stringent regulations and policies to govern the home health program. We believe that it makes no sense to pursue policies which encourage deinstitutionalization while hindering the ability of home health agencies to deliver the medically necessary service patients require upon discharge. We believe HCFA's actions are in direct contradiction to Congress' historic action to increase access to home care.

As a result of restrictive reimbursement policies developed several years ago by HCFA, the skilled nursing benefit is no longer available to many Medicare beneficiaries in need of nursing home care. Now HCFA has developed a series of policies to realize short-sighted savings in the home health benefit which will only lead to higher institutional costs down the road for those patients unable to receive the less costly home health services.

Over the last two years we have witnessed a series of actions on the part of HCFA which will reduce the ability of home health agencies to deliver services to elderly and disabled Americans. Acting with little or no consultation with affected providers and consumers, HCFA has:

- Proposed regulations which would have the affect of eliminating waiver of liability protection for home health agencies.
- Acted to reduce fiscal intermediaries serving freestanding home health providers from 47 to 10.
- Implemented new home health cost limits.
- Sought imposition of a $4.80 copayment on all home health visits after the twentieth.
- Attempted to change the rules to redefine "homebound" and "intermittent" in order to restrict the availability of home health services.
- Developed a massive new "minimum" data elements reporting requirement for all home health agencies.

(1)

WAIVER OF LIABILITY

HCFA issued proposed regulations in the Federal Register on February 12, 1985, to eliminate, in effect, waiver of liability protection for HHA's, SNF's, and hospitals. The comment period closed March 14, 1985.

Under the waiver policy currently in effect, HHA's with a quarterly denial rate of 2.5 or less are paid for denied services if it is determined that the HHA did not know or could not have reasonably known that the services were not reasonable and necessary, or constituted custodial care.

Congress instituted the current waiver presumption in 1972 to protect both Medicare patients whose care falls into an area of subjective judgment, and Medicare providers which need the protection in order to render services falling into the grey areas. The waiver presumption also serves to protect the beneficiary and the provider by providing a minimal "cushion" from what is also a subjective decision by an individual during the intermediary review process.

In the wake of publication of this proposed rule, associations representing HHA's and other Medicare providers, legal, consumer, and senior citizens groups formed a coalition to inform HCFA and Congress of the devastating effect loss of waiver would have on Medicare beneficiaries and providers.

The proposal is temporarily on hold as a HCFA task force considers its implications. Revised or final regulations may be issued later this year. We urge that this regulation be withdrawn altogether.

A preliminary report by the GAO to Senator Heinz, Chairman of the Senate Special Committee on Aging, indicates patients are being discharged from hospitals in a poorer state of health. Sicker patients will require more visits than those with the same diagnoses in the past. Loss of waiver of liability will make it difficult for some of these beneficiaries to receive needed home health services.

Home health agencies are cost reimbursed. They have limited capital resources to fund visits not covered under waiver of liability. Waiver allows access to care for patients whose care falls into the area of subjective judgment.

The case-by-case approach HCFA now proposes to implement will put an inordinate burden on many elderly and infirm beneficiaries who, in effect, will have to appeal denial decisions and prove the visits in question should be covered under waiver.

The performance of intermediaries makes waiver protection essential. HCFA now proposes to hold HHA's to a 100% standard of accuracy, while acknowledging a 32.4% rate of reversal on appeal for HHA denials. HHA's often receive inconsistent and unclear directives from intermediaries. The majority of HHA's will be transferred to new intermediaries shortly, exacerbating the denial problem for agencies trying to adapt to the policies of a new intermediary.

(2)

FISCAL INTERMEDIARY REASSIGNMENT

HCFA issued proposed regulations in the Federal Register on April 10, 1985, reducing to ten the number of fiscal intermediaries processing home health claims for freestanding home health agencies. The comment period closed June 10, 1985. It appears that HCFA plans to implement the reassignment of HHA's sometime between October 1, 1985 and February 1, 1986.

Reduction to no more than 10 intermediaries by July 1, 1987, was mandated by the Deficit Reduction Act of 1984. Congress enacted this provision to assure greater uniformity in interpretation of Medicare home health policy throughout the country. We have supported this move to ensure greater consistency in the application of coverage and reimbursement policy; however, we assumed HCFA would employ a more rational basis in the selection process. In the proposed regulation, HCFA mentions a number of criteria that it considered in selecting the 10 intermediaries; however, it gave no indication of how those selected rated in each of these areas or how their performance compared to intermediaries not selected.

HCFA states that a major criterion in selecting intermediaries is the ability to process bills electronically; however, four of the ten intermediaries apparently do not currently have this capability, making it difficult to comprehend why they were selected. HCFA states a desire to minimize transition problems, but it has selected several intermediaries which currently service only a relative handful of HHA's.

It is not clear where these small intermediaries will get the personnel to process claims. HCFA has not stated any policy on subcontracting. If they have to subcontract most functions back to the old intermediaries, it makes no sense to select them in the first place. If the ten intermediaries are going to subcontract audit, appeals, or onsite review functions to other intermediaries, it will lead to more of the same type of inconsistencies which Congress is trying to correct.

Contrary to Congressional intent, HCFA's proposed April 10th restructuring applies only to freestanding agencies and not to "provider-based" agencies (i.e., those which are hospital, nursing home, or rehabilitation facility-based).

We believe that HCFA should issue revised proposed regulations publishing the scores and rankings of the 10 tentative intermediaries, with an explanation of what actual considerations were used in the selection process, and applying them to all types of home health agencies.

(3)

COST LIMITS

On July 5, 1985, HCFA published in the Federal Register a notice retroactive to July 1, 1985 which abandons the current method of calculating the cost limits for reimbursement to home health agencies on behalf of beneficiaries who require and are entitled to home health care services. For the past five years, home health agencies have operated under a system which sets the reimbursement limit on each visit at the 75th percentile of overall national agency costs. The fact that the rates are currently calculated in the aggregate allows an agency the flexibility to provide certain kinds of care which exceed the cost limit cap. High cost services (e.g., physical therapy) and the cost of providing free care to indigent patients are offset by being under the limit in other services. The ability to aggregate allows an agency to stay beneath the cost limit overall, while providing the full integrated range of care.

The new method instead sets the cap at 120 percent of the mean of visit costs for each individual discipline and eliminates use of "aggregation". We have serious reservations about the methodology used to establish the new rates under this method.

I must mention that HCFA issued the final notice in the July 5th Federal Register in blatant disregard of a substantial number of requests from Members of Congress to delay finalization until Congress had completed its Budget Reconciliation Act. With so little advance notice, many agencies will be placed in a chaotic state. One fourth of all home health agencies have fiscal years beginning on July 1 (the date of implementation). They have already had their budgets approved for months, and hired staff accordingly. Another one half of the agencies have fiscal years beginning October 1, and most of these have already had their Boards approve the budgets. With so little advance warning, many agencies may be forced to reduce staff and services, or even close their doors. Particularly, such high cost services will be in jeopardy in terms of availability of beneficiaries.

Legislation (S.1450/H.R. 3202) has been introduced which would nullify this new methodology. Without Congressional intervention, we fear the result of this proposal will be to decrease the quantity of services available, but also may jeopardize the quality of care rendered to elderly and disabled beneficiaries.

The pervasive effect of this new regulation and its impact on home health agencies was best stated by HCFA itself and I quote in part . . . "the proposed limits would clearly have had a significant economic impact on a substantial number of HHA's. HHA limits set a 120 percent of the mean will result in a major impact on the HHA industry...more than 70 percent of the HHA's in our data base would exceed their limits in at least one discipline ...it would seem that around 3,800 HHA's could exceed the limits for one or more disciplines during cost reporting periods beginning on or after July 1, 1985."

This regulation will affect all home health agencies irrespective of their cost position as of July 1, 1985, in the following manner:

1) The level of home health services which Congress has mandated by statute for Medicare beneficiaries will be significantly reduced at a time when the demand for such services is sharply increasing. The reason for the increase is the enactment of a prospective payment(DRG) system for hospitals which creates incentives to move patients from hospitals into home care.

(2)
Cost Limits

2) Agencies will no longer offer important but costly services, such as physical therapy for which they will not be adequately reimbursed.

3) Agencies in rural areas will be devastated. Such agencies have significantly higher costs as they try to deliver services. Obviously, transportation expenses are much higher in these agencies which must often send their employees great distances to care for clients who otherwise go without health care altogether. In addition, therapists and social workers are often scarce and, therefore, more costly in rural areas. This increases the per visit length and cost. The policy of undermining rural home health agencies puts the Federal government in the incongruous position of spending millions of dollars in grants and loans to help create such agencies with one government program (the Public Health Service) and making it virtually impossible for them to serve clients through another program.

4) Agencies will drop out of Medicare. Hundreds of agencies will go bankrupt.

5) The level of paperwork required by the new system will increase dramatically, leading to higher Medicare costs; ironically, such costs will have no relation to the provision of Medicare care.

6) Agencies which provide so-called "high-tech" care, such as the care of ventilator-dependent persons, IV chemotherapy, or IV nutritional therapy will find it increasingly harder to do so. These services have relatively high costs and will be discouraged under the new reimbursement system. Ironically, these are among the very services which make it possible to move patients from hospitals into less intensive settings.

7) Agencies will be forced to be selective about which Medicare patients they take. Agencies may be reluctant to accept so called "heavy care" patients (such as stroke victims) whose cost per case is relatively high, and indigents. Agencies may well become selective in the distance they will travel to deliver care.

8) New agencies and small agencies will be hardest hit, regardless of how efficient they are. These agencies tend to have relatively higher costs and will be at an economic disadvantage. Older agencies will suffer to the extent they have tenured and, therefore, higher paid staff. The incentive will be to replace them with new staff members with lower salary demands. Obviously, the latter will have serious consequences as far as the quality of home care services.

9) Significantly, the proposal would either eliminate or sharply reduce care. The Visiting Nurse Services of New York, for example, gave $2.5 million in free care to indigents last year. The money was raised through private contributions. Such contributions will be needed to compensate the agency for Medicare losses in the future.

In our own Memphis area, we are faced with publically announced hospital cutbacks in indigent care. Many of us look to the private sector for contributions in order to fund delivery of charitable home care.

Cost Limits

My own Agency, Mid-South, in addition to seeking contributions, donates 100% of its total net income derived from private pay and third-party commercial insurance.

A recent freeze has been mandated in many sectors of health care. The home health industry stated its willingness to accept a freeze at the June 30, 1985 level. The freeze mandated to the hospitals was a restraint; they actually could have a rate of increase up to one percent.

As regards to the Physician Fee Freeze, the legislation providers participating Medicare physicians an update in customary and prevailing charges effective October 1, 1985.

Unfortunately, the home health industry was not considered in the legislative freeze. Worse, it was subjected to the Administrative cut backs I've already described.

(4)

COINSURANCE FOR HOME HEALTH CARE

Again this year, the Administration's budget proposal included a provision which would have imposed a co-payment on Medicare beneficiaries equal to $4.80 per visit after the 20th home health visit in a calendar year. Both provider and beneficiary groups strenuously opposed this proposal for a number of reasons.

The proposal would unfairly increase the burden on Medicare beneficiaries. Medicare beneficiaries are already required to make significant out-of-pocket expenditures to finance their own health care. Imposing a new co-payment for home health visits would increase the financial burden on beneficiaries and would result in patients going without needed home care or in unnecessary hospitalizations.

In addition, this proposal is totally contradictory to the goal of discouraging excessive utilization of institutional placement. Congress has taken several specific actions toward achieving this goal in the past few years, and we would be penny-wise and pound-foolish to reverse this trend. For example, the result of discouraging home care by the imposition of coinsurance will certainly be, that those who are being discharged early due to the DRG system will fail to adequately recuperate and will simply return to the hospital or nursing home.

Far from saving millions of dollars, coinsurance would result in increased costs to Medicare. Home health agencies and/or the government would be put in the position of collecting coinsurance from the elderly. The administrative costs in doing so would be enormous, and would necessarily be passed along to Medicare. Also, as former HCFA Administrator, Dr. Carolyne Davis pointed out in her April 1st testimony before the Ways and Means Committee, Medicare would have to cover the cost of non-paying beneficiaries by reimbursing agencies under the bad debt allowance. This will more than offset any savings which are anticipated from the implementation of coinsurance.

Some have expressed a concern about the overutilization of home care benefit and believe coinsurance will curtail this misuse. We reject this premise, and, in fact, the government's own statistics show 4.9 million Americans going without the home care or supportive services they need. The Heritage Foundation summed up the advantages of increased utilization of home care in its December 1984 report, Mandate for Leadership: "widening use of home health programs...would reduce cost considerably." Simply stated, the increased out of pocket costs will constitute a real barrier to quality care for those who simply cannot afford to pay.

Fortunately, both the House and Senate, in their respective Budget Resolutions, rejected the proposal. We remain hopeful that the Senate Finance Committee will also reject this proposal.

(5)

"INTERMITTENT CARE"

We are particularly concerned that the existing Medicare home health benefits is being unjustifiably limited, contrary to Congressional intent, by the Health Care Financing Administration (HCFA) and its contract intermediaries. This is being done by restrictive and inconsistent interpretations of the term "intermittent care" as defined in the Medicare statute which determines the nature and frequency of home care to nearly 2 million elderly, infirm, and disabled beneficiaries.

In creating the Medicare home care benefit, Congress stated that covered care was to be "intermittent", but did not specifically define what constituted "intermittent care." The Health Care Financing Administration issued guidelines on intermittent care to the fiscal intermediaries who process claims for home care providers. Under these guidelines, intermittent care would include daily care for a 2-3 week period, and thereafter under "exceptional circumstances." The major problem that has occurred with regard to these guidelines is the varying and inconsistent interpretations by fiscal intermediaries as to what constitutes intermittent care. Although Medicare is a national benefit, a Medicare beneficiary living in California can receive a substantially greater home care benefit than one living in Wisconsin. Some intermediaries consider "daily" to mean 7 days a week, but others consider it to mean 5 or even as little as 3 days a week. Some intermediaries view the 2-3 week initial period as a guideline and consider extensions of this period on a case-by-case basis: others see 2-3 weeks as a rigid cut-off point, regardless of medical resonableness and necessity as determined by a physician.

The implications of these varying and inconsistent interpretations of "intermittent care" are that there are thousands of cases where patients who have been authorized by physicians medically needing home care have been denied home care outright, or have had home care severely limited.

The implementation of the hospital prospective payment plan has exacerbated the already acute "intermittent care" problem, as documented by the GAO Report released this year to the Senate Special Committee on Aging previously mentioned in this testimony.

Senator John Heinz and Congressman Henry Waxman introduced legislation last year which would have defined "intermittent care" statutorily. This legislation, unsuccessful in the last Congress, has been reintroduced in this Congress (S.778/H.R.2371). Without the aid of such legislation, providers are "subject to the whims of fiscal intermediaries" in making key coverage decisions.

(6)

HCFA FORMS 443/444

In December 1984,HCFA issued Transmittal 158 to home health agencies requiring them to submit new forms (443 and 444) as a precondition of their receiving payment from Medicare. These forms were to be implemented on January 1, 1985. Home health agencies had no prior notice that these new forms would be issued. Nor were industry representatives consulted as to the issuance despite assurances by HCFA staff that open channels of communications could be expected. With Congressional intervention, the implementation date was postponed to February 15, 1985.

The new forms had serious flaws both in terms of design and content. They were never field tested. They would not fit into a standard typewriter. Computerized forms would not have been available until after the February 15 deadline, nor would computer specifications be available to the computer companies which help prepare billings for home health agencies. Further, the new forms substantially overlapped another computerized billing form (UB-82) mandated effective October 1, 1985. HCFA acknowledged that the new forms were problematic and agreed to redesign them before they were printed new in June 1985. However, the agency refused to delay the February 15 implementation date.

Through substantial industry efforts and and subsequent intervention of Congress, HCFA eventually delayed the implementation of these forms to September 1, 1985 and worked with home health providers and industry representatives in redesigning the forms now known as HCFA Forms 485-486. Had HCFA worked with providers prior to issuing these forms, Congressional involvement and significant provider concern could have been averted.

REGARDING POSSIBLE SHORT-TERM OR LONG-TERM SOLUTIONS TO THE MEDICARE TRUST FUND CRISIS:

Congress has already imposed a series of health cost cuts in the recently enacted budget resolutions:

> 2.5 billion dollars from Medicare and Medicaid in fiscal year 86 and 11.3 billion dollars over three years. These cuts obviously will have an affect toward easing the Medicare Trust Fund crisis.

Home health care has a proven record of reducing hospitalizations and other forms of expensive institutionalization. We recommend that the utilization of home health be increased and substantially reduce reliance where practical, on inpatient or institutional care. The expansion in home health should include wellness and maintenance programs. Consider tightening up on controls in fraud, abuse, and continue to focus in on where over 90% of our medical dollar outlay is spent.

Again, in regards specifically to Home Health, we would support a prospective payment program as an alternative reimbursement policy; one that properly balances the needs of beneficiaries, insures quality care, and fair and adequate payment to the Home Health provider. We would ask equal treatment in terms of outliers and exceptions to the prospective payment system as is currently afforded hospitals.

For the relatively short-term, there is an almost immedidate savings that can be accrued, to the Medicare Trust Fund. I refer back to my earlier comment on Cost Limits and the Federal Register notice of July 5, 1985. That notice approved cost caps significantly higher for hospital based home health agencies than for freestanding home health agencies. For example, in the Memphis area the difference is:

Nursing Visit - 11.36% greater

Physical Therapy Visit - 9.83% greater

Speech Therapy Visit - 10.41% greater

Occupational Therapy Visit - 10.12% greater

Medical Social Worker Visit - 10.44% greater

Home Heath Aide Visit - 13.78% greater that free standing Agencies.

The Health Care Finance Administration acuaries estimate this excess cost to the nation for the utilization of hospital home based agencies will total 130 million dollars over the fiscal year period 1985-1990. Specifically, the government has approved the use of an add-on adjustment for hospital based home health agencies to account for the higher cost associated with hospitals allocation of General & Administrative costs.

This disparity can be corrected with immediate savings and on-going savings to the Medicare Trust Fund, by eliminating this add-on adjustment for hospital based home health agencies. It will place hospital home health agencies on an equal footing with freestanding home health agencies.

CONCLUSION

In light of the problems I have discussed here, we urge the Congress to take the following action:

1) Congress should enact legislation (S.1450/H.R.3202) to forbid the implementation of the new cost limits during the period of any freeze on Medicare providers reimbursement.

2) Congress should direct HCFA to : (a) fully withdraw the proposal to eliminate the presumption of waiver of liability, and (b) withdraw the provision in the regulation permitting hospital based home health agencies the G & A add-on adjustment.

3) Congress should enact legislation to statutorily define "intermittent care", S.778 and H.R. 2371, as soon as possible.

These actions would go far in protecting the Medicare beneficiary's right and access to home health care. I thank Senator Sasser and the members of this Committee for the opportunity to appear here today and would be pleased to answer any questions you might have.

Senator SASSER. We'll have a question or two but first we'll hear from Ms. Stitt.

STATEMENT OF CATHEY P. STITT, VISITING NURSE ASSOCIATION

Ms. STITT. Thank you, Senator Sasser. I'm pleased to be here to share with you as a provider of home health services some of my concerns regarding the current Medicare regulations and the future directions of the Medicare Program. I'm going to speak with you not about the technical aspects but about what's happening to people out in this community. As most of you are aware, the VNA's came into existence and provided home care prior to the implementation of Medicare and Medicaid. With the implementation of these programs access to care was made available to those who had previously been denied, because of lack of financial resources, the realities of receiving care.

In the intervening years since the advent of Medicare we've seen numerous changes in rules and regulations and in 1981 the Congress passed an intent of the Omnibus Reconciliation Act to remove visit limitations in home health. It seemed we were headed in the right direction of cost containment under the Medicare program.

HEADED TOWARD THREE-TIERED SYSTEM

Now, with the implementation of DRG's, cost caps by discipline, intensified medical review—intensified medical review being evaluated by the intermediary, failure to define definitions of intermittent, homebound status and what's medically reasonable and necessary are we now once again headed toward denial of access to care that is truly needed and are we not clearly headed toward a two-tier health care system that will be composed of those who have and those who have not?

My fear at the current directions is that we will have a three-tiered system, the have's, the have-nots and those who are simply squeezed completely and totally out of that system.

EXAMPLES OF HOME CARE SERVICES

I'd like to share with you just a couple of situations with patients to give you some idea of what's happening in the community. We recently admitted a patient following hospitalization who ideally should have been in a nursing home. However, the patient and his family chose home care for several reasons. They have familiar surroundings. There was care by the loved one and there were economic needs involved. This couple has been together providing support for each other throughout their married life. A separation at this point would be detrimental to both.

The wife was counseled about the realistic aspects of taking care of someone in the home 24 hours a day. The care needed consists of turning the patient every 2 hours, gastric tubes needs goes every 4 hours, extensive decubitus care, bed sores, and personal care, personal hygiene for the patient. We're in the home right now to teach her home health aid, how to provide that care.

SERVICES ARE ON AN INTERMITTENT BASIS

Again our services are on an intermittent basis, meaning we visit the home as often as needed until the teaching needs are met. Our visit frequency will decrease as care is learned and the visit time lasts from an hour to an hour and a half. At the point the decubitus have healed and the Levene tube is no longer necessary Medicare regulations require that services be continued (sic) because maintenance or preventive care is not a covered service. Therefore, the home health aide can no longer an assist the wife with the personal needs of the patient. This man requires 24-hour-a-day care.

Senator SASSER. How old is the wife?

ALTERNATIVE OF PLACING PATIENT IN NURSING HOME

Ms. STITT. The wife is 64 years old. The husband is 67. He's bed ridden. He's not going to get out of the bed. That's a heavy burden to carry. We have some other situations which will point up some of the inadequacies in the system and what the cuts are going to mean. The alternative of placing this patient in a nursing home would mean not only the separation of this couple but the wife will lose a major support portion of her Social Security income. He earns more under Social Security than she would be able to draw herself. What she will be able to draw on Social Security is not adequate to meet her living needs. She has an economic need to keep this man in the home as well as a love need to have him there.

We had another patient, a recent service request involved services for a 70-year-old patient with lymphoma, a form of cancer. Prior to this hospitalization she had been living alone in a small apartment. She has married children who live out of the city and work outside their homes. She was hospitalized for chemotherapy and she now has a Hickman catheter which will allow chemotherapy to be continued on an out-patient basis. The physician's office will handle this. However, the catheter care must be given site care daily and it must be flushed. This care must be provided by someone.

Under the Medicare rules we cannot go out and provide those services for that patient, only for a short time. I'll explain a little further. The family has had to hire someone to care for this patient while they work. Resources prevent their hiring someone other than a skilled person. Medicare will allow us to assess their ability to give the care and they will allow us to do teaching where that is deficient. However, at the end of that time we will have to withdraw from the case and someone will have to continue the care.

FAMILIES ASKED TO SIGN AWAY LEGAL RIGHTS

Senator, we have great concerns about this situation. The family has asked us to teach a nonprofessional person and we will do this. But, the agency is assuming a terrible liability in terms of an untoward event. We are asking this family to sign away their legal rights should there be an event so we can make sure that the care is provided. It's very difficult. Not all agencies are in the position to do that and certainly many families are not willing to do this.

We have another patient who was a stroke patient who's basically become stabilized and requires total care. Our skilled care under the Medicare provisions is that of changing a Foley catheter monthly. When this patient was first discharged from the hospital it was clearly determined he would need 24-hour care. Attendant services were initiated because the wife is not able to provide that care, Senator, due to a crippling arthritis and she has a heart condition. She cannot lift this patient.

PATIENTS FACE FRIGHTENING SITUATIONS

The attendants were taught to do the catheter care and the needs of the bedridden patient. The family savings are close to depleted because of the expense of the attendant care services for several years. They will eventually become an economic drain on their son and his family. Their needs are currently being met, however, it will not be able to continue for an indefinite period of time. If we look at a nursing home placement for this patient, there will have to be economic resources found to provide that care because he will not meet the skilled care needs under Medicare and he does not qualify under Medicaid for services.

These are frightening situations to patients in the community. We have a gentleman that lives alone. Cardiac disease, diabetes, and he's nearly blind and he's on daily insulin. We're providing a nursing visit weekly and a maid twice a week and a homemaker and she's just unstable enough to meet the Medicare qualifications for skilled care. When we stabilize her with we've got a dilemma. She cannot fill her insulin syringes. No one covers that under services and this patient will begin to deterioriate again and she will be rehospitalized and she will come out of the hospital again and we will go out and try to restabilize her and we will continue in a vicious cycle until she probably dies. And this is a very real concern for a number of people. There is a cyclic system that is not meeting the needs of patients in the community.

NEEDS BEING DETERMINED BY BUDGETARY SYSTEM

I think I'll stop telling you about patients and tell you that I have some concerns, that we have a crisis and that our health care is being determined, our needs are being determined by a budgetary system instead of us determining our needs and finding a budgetary process and the dollars to produce a system that's real. We're becoming—the cuts that are being placed are causing a fragmentation of care and we have no systems to support that.

I will give you an example. If I'm discharged from the hospital and I need meals delivered to my home there are services such as that in this community. There's a waiting list, Senator. It's 6 weeks maybe before I can get a meal delivered to my home. I will be starved by then. Patients do not have access to the community resources for a long-term care system and we are very quickly through the Medicare cuts creating a tremendous need for long-term care and there are no provisions that have been made to adequately support the number of people that will be involved. And I think I will stop there.

Thank you very much, Ms. Stitt.

[The prepared statement of Ms. Stitt follows:]

TESTIMONY OF: MS. CATHEY P. STITT

VISITING NURSE ASSOCIATION
AUGUST 28, 1985

SENATOR SASSER AND OTHER DISTINGUISHED COMMITTEE MEMBERS:

I am pleased to be here to share with you, as a provider of Home Health Services,my concerns regarding the current Medicare regulations and the future directions.

As most of you are well aware, VNA's came into existence and provided home care prior to the implementation of Medicare and Medicaid.

With the implementation of these programs, access to health care which had been previously denied those patients without financial resources became a reality.

In the intervening years, we have seen numerous changes and interpretations of the regulations.

In 1981 it appeared we were heading in the right direction with the removal of visit limitations. Now with the implementation of DRG's, cost caps by discipline for home health, intensified medical review, failure to resolve home health definitions of "intermittent," "homebound status," and "medically reasonable and necessary," are we not, once again, heading toward a denial of access to care needed and clearly, a two tier health system of those who have and those who have not.....where care is determined by the ability to pay????

The Middle Class is being squeezed out of the system. Actually Sir, the system will take care of the very poor and the rich will be able to afford care but the Middle Class will and are finding that additional services are needed because of earlier hospital discharge and the patients are more

acutely ill. These services (Sitters, Companion, Homemakers or Private Duty RN's) are already non-covered by Medicare. The cost to families can be $200 - $450 per week for a Sitter and up to $2500 - $2900 for an around-the-clock RN. Most of the Middle Class cannot afford these services but more and more will need them because of the "greying" of America, the mobility of family members with relatives scattered throughout the country and the independent nature of Americans and our dislike for institutionalization and because also we're sending them home less recovered under DRG's,

Unfortunately Senator, the one area that currently gives support to these families after discharge from the hospital is now under unreasonable constraints and limitations imposed by HCFA and seemingly without consideration of what is and will happen to the beneficiaries.

I would like to share with you some specific patient situations:
We recently re-admitted a patient following hospitalization, who, ideally, should have been placed in a Nursing Home. However, the patient and his wife chose home care for several reasons---familiar surroundings, care by a loved one, and economic needs.

This couple has been together, providing support for each other throughout their married life. A separation at this point would be detrimental for both. The wife was counseled on the realistic aspects of the needed care and the care that could be provided through the home health provision. The care consists of turning every 2 hours, nasogastric tube feedings every 4 hours, extensive decubitus care 3 times per day and personal care.

We are in the home to teach her and the Home Health Aide how to provide the care. Again, our services are on an intermittent basis, meaning we visit the home as often as needed and until the teaching needs are met. Our visit frequency

will have to decrease as the care is learned. Visit time ranges from 1 - 1 1/2 hours per visit.

At the point the decubiti heal and the Levine tube is no longer necessary, Medicare regulations require services be discontinued because maintenance and/or preventive care is not a covered service. Therefore, the Home Health Aide can no longer assist the wife with personal care needs of the patient. This patient will always be dependent on the wife for personal care and can never be left alone.

The alternative of placing this patient in a Nursing Home would mean not only a separation of this couple, but the wife would lose a major portion of support because her individual Social Security income is not adequate for meeting her needs for food, clothing, shelter, etc. Her only alternative is to sell her home!

A recent service request involved services for a 70 year old patient with Lymphoma (a form of cancer).
Prior to this hospitalization, she had been living alone in a small apartment. She has married children who live out of the city and who work outside their homes.

She was hospitalized for chemotherapy and now has a Hickman catheter which allows feedings and chemotherapy directly into the heart where it is pumped out into the system.
The chemotherapy will be handled by the physician in the office when needed, however, the catheter site care and twice daily flushing of this catheter must be provided by someone.
The family has had to hire someone to care for this patient while they work. Resources prevent their hiring someone other than a non-skilled person.

Medicare will allow us to assess their ability to care for the catheter and

provide additional teaching if needed, to assess her status, etc. Twice daily visits to care for the catheter are not covered under Medicare home health benefits. Yet, HCFA is placing increasingly restrictive interpretations on the benefit so that if the family hires a non-skilled person; the nurse visits (which are covered) may be disallowed.

Senator, we have grave concerns over this situation, the liability involved should an untoward situation develop, however, the family has no other alternative. This is related to the definitions of "intermittent" and the new POT 483 Question 11.

Senator, I believe I'll stop here with patient examples. I think you can see that we have a real crisis in health care and among consumers who are attempting to adapt to the changes mandated by the budgetary process; however, that process has made no real provisions for the very real and varying levels of care now needed as a result of the Medicare cutbacks. We are having more care shift to the patient and family who are frequently ill equipped and unfamiliar with how to give this care and frequently are physically and/or financially unable to provide it.

Senator, we need to leave the home health benefit intact as much as possible until we can find adequate alternatives such as the long term care systems being proposed now. Until these systems are in place, families need what little support is available and it is being systematically withdrawn via sudden and restrictive interpretations of coverage guideline and by disallowance of home health cost caps as of July 5 to be figured in the aggregate.

I urge the Senate to restrain HCFA from unreasonable cost containment mechanisms that work to the detriment of the beneficiaries.

Question #1:

Ms. Stitt, from your experience, how has the current Medicare reimbursement system impacted your patients?

ANSWER:

There is a clear cut need for more intensive and high tech care as patients are discharged earlier and earlier from the hospital. There is also an increasing need for non-intermittent services such as Sitters, Aides and RN's in the home to support family or to substitute for them.

QUESTION #2:

If there are further Medicare cuts in reimbursement to hospitals and home health agencies, what do you believe will be the consequences for Medicare beneficiaries?

ANSWER:

If there are further cuts without adequate and affordable support systems, there will simply be a lack of care and increasing number of people squeezed out of the system. So much depends upon an intact family support system. Unfortunately our society is no longer truly structured this way. It's hard and frequently impossible for a working son and daughter-in-law living two states or more away to drop everything to care for mother or father. Even if they uproot the parent, there's frequently no one to care for them during the day.

Usually the second income is a necessity not a luxury for today's family.

If you sell the parent's home, that $25,000 to $150,000 can be depleted in a matter of a year or less.

Churches and neighbors are helping but this is dependent upon the willingness of an individual and they are being asked to coordinate care for which they are unfamiliar. Chronically and terminally ill patients frequently are asking neighbors to assume some aspect of their care on an on-going basis.

Question #2 (continued)

Most Nursing Homes in this area have a waiting list---if you have to leave the hospital and can't find a vacancy at the Nursing Home, then you must go home with increasingly minimal support. Home Health is great for a larger and larger number of people but that is being restricted more and more. The "no-care zone" is increasing. The beneficiaries are being left to cope as best they can and the effectiveness is largely dependent upon their financial resources.

Question #3:

Ms. Stitt, can home health agencies fill the patient's needs which exist as the result of current Medicare policies?

ANSWER:

Home Health can meet many of these needs but not all and again there are the same two problems: 1) restrictive interpretations and per discipline cost caps, and 2) the lack of non-skilled and non-intermittent services that generally are not available to the middle class.

Mrs. X is a good example. She's 83 years old, lives alone, has cardiac problems and diabetes, is nearly blind and is on daily insulin. We are providing a weekly nursing visit to draw blood, fill insulin syringes and an aide twice a week and a homemaker. She just barely qualifies for the current Medicare requirement and with the new interpretations, she may not meet them. What we are faced with is that when she stablizes, services will be withdrawn and this patient will quickly deteriorate and probably require rehospitalization and restablization which is a continuous vicious circle.

Home Health can provide for those who have some family support and who are acutely and/or chronically ill. We can provide care and teach families how to cope. We can assist in returning individuals to a functional level of

independent living. However, there simply is very little out there if 1) you don't require skilled care and 2) have a reasonable income above the poverty level and need some ongoing or even short term support to continue to be at home. Unfortunately, more and more people fit this category as the result of the current Medicare policies.

I'd like to describe another case for you which is a situation occurring more frequently and seemingly intensified by DRG's. It is a situation where families are unable to provide care and seek relief via non-skilled personnel for which they must pay:
A stable, male stroke patient who requires total care and our skilled care is changing a Foley catheter monthly.
When first discharged from the hospital it was determined he would need 24 hour care. Attendant services were initiated because his wife could not provide care due to crippling arthritis and a poor heart condition. The attendants were initially taught catheter care and the needs of a bedridden patient.

Their savings are nearly exhausted because of attendant services and eventually, they will become an economic drain on the son and his family. Their needs are currently being met, however, because of care required, the alternative,separation from one another and Nursing Home placement,will occur or if further resources cannot be obtained, the husband's future is in doubt.

I have seen instances where families, even prior to these cutbacks, have become so exhausted from the burden of care, that they themselves become ill. These cutbacks will only serve to magnify this situation. As more costs are shifted to the individual, the dilemma becomes more difficult.

When Social Security income is $420 and medications run $170 per month (which have never been covered by Medicare), and you have rent or a mortgage of $100-$150, by the time the patient pays utilities, food, transportation to the doctor, they do not have any extra money and in most cases not enough---- they sometimes unwisely choose which medication to skip. I'm sure our society does not want to endure the consequences.

QUESTION #4:

Under current Medicare, what does the future of our home care system look like from your prospective?

ANSWER:

Right now, under the current Medicare Regulations, home care is being systematically dissolved into an ineffective and non-responsive system.

The savings being brought by recent rules and regulations will be negated by readmissions to hospitals and worsening of previously controlled conditions. I find HCFA'S choices somewhat ironic!

There are two ends of the spectrum of care: 1) High tech and 2) short term and/or long term supportive care. However, there is a tightening of rules with HCFA Forms 485 & 486 which appear to be geared to more intensive review of intermittent definition and of other care being rendered. We are being asked to describe supplemental treatment and who pays for it. There are also questions asking the professional staff to report how often and why a patient leaves his home and if a patient is not home, the Agency is asked for an explanation.

We are concerned that if we try to teach supplemental - non-skilled paraprofessionals hired by a family--that the intermediary will interpret the Agency's teaching as not meeting the intermittent requirement. Likewise increasingly restrictive measures seem to be operationalized via questions to the Agency with regard

to medical necessity and homebound status. That means fewer will qualify who truly need the service.

Currently under July 5, 1985, regulations, a lowering of the cost cap to 120% of the mean and a change in methodology of figuring the caps (from the aggregate to a per discipline basis) has or will cause our Agency to consider the following:

1. Whether or not we can continue to offer Physical Therapy, Occupational Therapy and Speech Therapy because we will be over the caps and will lose money everytime we make one of these visits. (It's a problem for many Agencies not just mine).

2. In order to meet the caps, we may have to discontinue services to rural areas because of per discipline caps. It becomes an Agency disadvantage and a financial liability to send a P.T. or anyone to rural areas in Tennessee, Mississippi and Arkansas where travel time can approach 30 to 50 minutes and therefore reduce efficiency.

3. Home Health staff have traditionally been underpaid (with a few exceptions of those personnel who can demand higher pay due to geographic distribution or a scarcity of certain credentialed professions). VNA is currently planning to discontinue it's Retirement Plan which has been in place since the late 50's, we've already laid-off staff, and we don't know how we can acquire new computer equipment necessary for electronic Plan of Treatment required recently in order to submit claims electronically and to remain on PIP - Periodic Interim Payment.

It is certainly ironic that we are forced to discontinue a Retirement Plan for the caregivers of today who will need care in the future and Senators, the vast majority of these people in our Agency earn under an average of $15,000 per year so their savings is not likely to be an astronomical amount.

In summary, the future of home care is dim. Many Agencies will go out of the business. The proprietaries who fought so hard to be part of home health have already started to abandon the Medicare program. Dropping of certain high cost services delivered to high cost areas is a denial of access to care that has been mandated.

Senator Sasser and Distinguished Committee Members, thank you for listening. I urge you to restrain HCFA and the Budgetary process from further changes until we can find compromises that will not devastate the beneficiaries-- Home Health should take cuts as other areas have but with planning and a phase-in process. Lowering the mean on caps is at least survivable for many Agencies. The methodology changes to per discipline caps will mean "no care" for many!

MIDDLE CLASS WILL BE SQUEEZED OUT

Senator SASSER. You mentioned a three-tier health system of have's, have-nots, and those squeezed out totally. Could you elaborate on that? Who falls in that third category?

Ms. STITT. Senator, it's going to be the middle class. It's going to be very much I believe Mrs. Lapides. They're going to either have to opt out of the system because they're not able to afford the care, but are going to sell their home and everything they've worked for in order to afford the care.

Senator SASSER. I thought that's what the Medicare system was all about, to keep people from having to do that.

Ms. STITT. Sir, it may have been what it was designed for initially but the cuts that are coming across the board now are going to force people into that position. They must have the support and it is not covered by Medicare. The services that are needed in terms of attendants and aides.

Senator SASSER. Well, based upon your observation and experience in this field, what would be the timetable on forcing middle-class people into this third tier of being squeezed out?

DRG'S FORCING PEOPLE OUT OF SYSTEM

Ms. STITT. It's beginning now. We have not yet seen the full effect of the DRG system. Most hospitals are only into their second year of the implementation of DRG's.

Senator SASSER. How are the DRG's forcing people, Ms. Stitt, out of the system?

Ms. STITT. Patients are being discharged earlier and——

Senator SASSER [interposing]. When their DRG funds run out then they're being discharged?

Ms. STITT. In some situations certainly. There's an economic incentive——

Senator SASSER [interposing]. For hospitals to get them out?

Ms. STITT. They simply must or they're going to go out of business. These patients come out of the hospital in need of more intensive care than they have needed in the past. They are weaker and they are sicker. Because of this they must have more care in the home. What's happening, Senator, is that Medicare is cutting back in home health restricting limits and there are no financial resources for the care beyond what's available under the Medicare system. The families are having to either work a second job, mortgage the home in order to pay for that 24 hour-a-day attendant care that's needed.

Senator SASSER. So, you and Mr. Vizzi are saying that the patient or the beneficiary is getting a double whammy here and they're being forced out of the institution because of the DRG system and they have the institution, hospital, prematurely and they require extensive home health care. But, home health care has also been cut back to the point that the home health care is not adequately available?

Ms. STITT. Exactly.

INCREASED UTILIZATION OF HOME HEALTH CARE RECOMMENDED

Senator SASSER. Mr. Vizzi, what suggestions can you offer us today that will both control Medicare costs yet at the same time provide quality home health care? Do you have any suggestions along that line?

Mr. VIZZI. Yes, sir, Senator home health care has a proven record of reducing hospitalizations and other forms of extensive institutionalization. We rercommended the utilization of home health be increased and substantially reduce reliance where practical on in-patient or institutional care. The expansion in the home health should include necessary as well as preventive maintenance programs. Consider tightening up on controls in fraud and abuse and continue to focus in on where over 90 percent of our medical dollar outlays is being spent today.

PROSPECTIVE PAYMENT PROGRAM SUPPORTED

We in home health would also support as a means of controlling costs a Prospective Payment Program as an alternative reimbursement policy, one that would properly balance the needs of the beneficiary, insures quality care and fair and adequate payment of the home health provider. And we would expect, we in the home health industry would expect that whatever that prospective payment system would be that it would afford the home health agencies equal treatment in terms of outward and exclusions compatible in scope to the hospital DRG system.

Senator SASSER. That you, very much. I believe you anticipated that question there, Mr. Vizzi.

Mr. VIZZI. One of about 50.

QUALITY AND QUANTITY OF CARE AFFECTED

Senator SASSER. I want to thank both of you for appearing here today. I gather overall from your testimony, what you're telling us is that the recent efforts to economize in the Medicare system and

to reduce the inflation in the Medicare system has had a deleterious effect on the quality of care and the quantity of care that's available for Medicare patients, both in the hospital and in a home health care setting.

Mr. VIZZI. Precisely. As the Medicare reimbursement gets less and our costs increase the incentive is actually to reduce costs which unfortunately may or may not—could reduce the quality of care. So, it's a double-edge squeeze play that we're being faced with.

Ms. STITT. Senator, I think that we're not talking about what if's at this point. My own agency currently is considering whether or not to discontinue all therapy services because we cannot get up underneath the caps to do a variety of factors. That means patients we serve will have to get those services elsewhere or perhaps not at all. We are looking at not going into northern Mississippi into the rural areas, not into rural Arkansas or to rural Tennessee because we can't afford to go and lose money every time we make a visit. We will be out of visit and we're a charitable organization, sir. These things are going to happen. And clients are in jeopardy.

MIDDLE CLASS WILL BE SQUEEZED OUT

Senator SASSER. You're taking the position, Ms. Stitt, that those who can afford to pay for health care will be all right in the years ahead, that they will have adequate health care, that those who clearly cannot afford to pay for it will also get reasonably adequate medical care through charity or other means. But, it's the broad middle class that's going to be squeezed out here and have to eliminate their limited financial means in an effort that you think by and large would be unsuccessful to get adequate health care.

If that is indeed the case then the whole reason for being behind the Medicare system—if you're accurate in that assessment, the whole reason for the enactment of the Medicare system 20 years ago will have been largely depleted.

I thank both of you for appearing here today and testifying. Your testimony has been very useful.

Our next panel of witnesses will consist of representatives of the hospital industry and we're looking forward to hearing from them. Mr. Phillip Sowa is the president of the Regional Medical Center here in Memphis and is employed by the Shelby County Health Care Corp. I might say by way of introduction that Mr. Sowa has previously served as assistant executive director of operations for the University of Louisville and was associate administrator of St. Francis Medical Center in the State of Missouri.

His educational background is that Mr. Sowa holds a master's degree in hospital and health care administration from St. Louis University and is currently active in many State, local and national organizations devoted to better health care. I'd also like to take this opportunity, Mr. Sowa, to express my personal appreciation to you for providing these facilities today.

Mr. SOWA. You're welcome.

Senator SASSER. We'll also call Mr. Calton, who is currently president of the Methodist Hospitals of Memphis. And I have a sentimental attachment to that hospital, Mr. Calton. I was born there,

as Jack Benny would say, 38 eight years ago now. Mr. Calton is the chief executive officer of one of the fifth largest private hospitals and the largest Methodist hospital in the country.

He's been in the health care field since 1955 and joined the staff at Methodist Hospital in 1978. By way of qualification he is a fellow of the American College of Hospital Administrators and immediate past president of the Memphis Hospital Counsel and the Hospital Alliance of Tennessee. He has served on the Governor's select committee on health care cost containment.

Mr. Calton received his bachelor's degree in psychology in 1953 from Berea College in Kentucky and a master's degree in administrative medicine in 1959 from Columbia University in New York City.

Gentlemen, we welcome you here today. We'll start first with you, Mr. Calton.

STATEMENT OF JUDGE CALTON, PRESIDENT, METHODIST HOSPITALS OF MEMPHIS

Mr. CALTON. I appreciate the fact that you were born in Methodist Hospital. That says something good about you. And we're glad that you have——

Senator SASSER [interposing]. I'm delighted to have any small thing good said about me.

Mr. CALTON. We're glad that you have come to Memphis to hear us on the very important issue of the Medicare Program. And on the front end I think that all of us would tell you that we do not expect all of our social problems to be solved in Washington, DC, but certainly you can be of some help to us. I am going to speak from a rough outline. If I drift too far timewise, Scott, if you'll raise your hand I will quit. If you have any questions about anything I say, I'll be glad to talk to you later and I also offer you all of the resources of the Tennessee Hospital Association if there's information from that source that you need.

Senator, health care is very expensive. Hospital cost is too high for most Americans to afford from their own resources and in the absence of third-party mechanisms such as Medicare, Medicaid, employer provided insurance, and other mechanisms many Americans would not get all of the health care that they need.

The charts which you present up here are very dramatic and I'm glad in your statement that you indicated that you're not placing blame anywhere because those of us in the hospital field often think that we have become the whipping post for the hospital cost issue and it is a little frustrating at times. You made reference in your opening remark to the increase in the cost of health care compared to the rest of our economy and that is often used without explanation.

VALUE OF HEALTH CARE HAS INCREASED

I think when we use those numbers we do need to take into consideration the value of what we are receiving for those increases in cost. When I say that the cost of hospital care is too high, I'm also prepared to say that the cost of food, utilities, government and other services are too high. But, look at value in relation to food.

When I walk in a supermarket today I essentially buy the same food that I bought 20 years ago. Now, it has been repackaged and presented in a much nicer way. There are some products which resemble food which are not food. But, by and large, I am buying the same food that I bought 20 years ago.

If I look at electricity and walk over and plug a lamp into that outlet on the wall I'm essentially getting the same electricity that I got 20 years ago. I understand in the background we have made the transition from steam generated power to atomic generated power and that sort of thing. But, in the health care field I think we have a slightly different situation. We have developed one of the greatest health care systems in the world. I think we can be proud of that.

If we look at the value of what we have received for the cost increase I think all we need to do is compare what would have happened to a patient with cancer 20 years ago, a patient having a heart attack, a patient having a stroke or a premature baby. Their prospects for surviving and enjoying a good life today far exceed what it was 20 years ago. So, we have received some value for our investment.

HOSPITALS RESPOND TO DRG REIMBURSEMENT SYSTEM

The question now is how much can we afford and how do we go about developing a system that matches what we can afford. On the Medicare reimbursement issues hospitals have responded to the challenge of DRG reimbursement. Prices are down more, or were down more in 1984 than in any year that I can recall. As a matter of fact, we are somewhat puzzled that the DRG system is being stalled at the 50-50 arrangement instead of proceeding as it was planned in the beginning. Given that it has been successful in containing cost.

Now, we understand that there are States where cost has historically been high and that the transition to a full DRG reimbursement system would not be advantageous to those States. I can tell you it would be advantageous to Tennessee. Hospitals have remained healthy under the DRG reimbursement system but it has been at some expense to the economy of Tennessee. We have had to make cost reductions in order to stay healthy within the DRG program. Starting out in a major way with personnel reductions and to give you an example of the extent of that Methodist hospitals during this year reduced its staff by 300 employees; the Baptist Hospital reduced its staff between 400 and 500 employees. Representatives from St. Francis said yesterday that they have fewer employees today than they had a year ago. And we have done other cost-saving measures, moving to ambulatory care, joining group purchasing arrangements and other activities.

DEPRECIATION FUNDS SUPPORT OPERATING COST

I don't want to mislead you and let you think that all hospitals in Tennessee are healthy. They are not. Those hospitals which are predominantly caring for Medicare/Medicaid patients are having a tough time. There's about 165 hospitals in Tennessee and I have been told recently that somewhere in the neighborhood of 60 of

them are currently using their depreciation funds to support their operating cost.

Now, given all of that, in terms of the response to the DRG system——

Senator SASSER [interposing]. One third of the hospitals in Tennessee approximately are using their depreciation cost to support current operations?

Mr. CALTON. That's the information given to me by the Tennessee Hospital Association. We have gone through many things in response to the DRG reimbursement system and we're left with two concerns. One is the question of the quality of care. Are we doing something which ultimately will show up as a deficiency in terms of quality, and second, are we short changing Medicare patients.

You have heard the statement, hospitals are forcing Medicare patients out of the hospital. I don't like the use of that term. I think Medicare patients are being discharged earlier than they have been in the past. But that is a decision which is made very carefully by the physician and somewhere down the road we'll have to measure whether or not that's having an adverse impact. It possibly could be. Hospital administrators have three great concerns related to the reimbursement system.

First, will we gradually drift into a system of rationing health care as the availability of funds to support health care decreases? Second, are we going to be compromised in keeping up with the massive technological advances that are made in our society? And third, are we going to be able to sustain the same levels of care we have been providing to those people who do not have any third-party sponsorship and cannot pay for health care themselves?

In the State of Tennessee in 1984 hospitals provided over $300 million worth of care to people who were unable to pay. By the way, Mr. Vizzi mentioned that the Memphis hospitals had made a statement that it was reducing its indigent patient care or a public statement. We didn't make the statement. We made a casual comment to someone and it became a public statement. I want to tell you and Mr. Vizzi we have been notoriously unsuccessful in controlling indigent patient care.

PROPOSED CHANGES IN MEDICARE REIMBURSEMENT

As a matter of fact, through the month of July we have spent $500,000 more than we did during the same period last year. Four, there are some proposed changes in Medicare reimbursement and I'd like to comment on just three of those. One relates to the freezes on Medicare price increases. The hospital industry sort of feels it took its hit trying to deal with the budget deficit when we made the transition to DRG's and now we're coming with a second round.

Basically we're getting caught in a dilemma. While the Federal Government reduces reimbursement for the care of Medicare/Medicaid patients, business and industry is exerting a great deal of pressure on us because of the cost increases they have been experiencing and specifically on the issue of indigent patient care because we've been shifting the cost of that to the backs of business and industry.

Now, when you look at those we're caught between two mechanisms that are moving in the direction of reducing reimbursement. And the translation of that simply is less reimbursement means less money and ultimately less money has to mean less service. The second area is medical education. There is a proposal to reduce indirect medical education adjustment and to place a freeze on medical education.

That may be fine but we need to remind everyone in this country that medical education programs, which is the training of physicians, interns and residents, is the first line of care for the indigent population of this country. And if those medical education funds are reduced it compromises the ability of hospitals which are providing the large chunks of indigent patient care in the provision of that care.

The third area is the freeze on capital pass-throughs. Currently capital costs are exempt from the DRG reimbursement and the proposal is to make some change in that. One of the discussions has been along the lines of let's look at capital cost as a percent of total Medicare cost and the number used has been 7 percent—and apply that 7 percent to the DRG reimbursement of each hospital. That may sound reasonable until you look at the fact that a hospital like Methodist Hospitals of Memphis has capital costs which is equal to 19 percent of its Medicare reimbursement. And if that program was implemented in that form we would lose 50 percent of our budgeted capital dollars.

SEVERITY OF ILLNESS NOT TAKEN INTO ACCOUNT

If we look at all of the changes that are proposed in the way of freezes, reductions and so on we're looking at Methodist Hospitals of Memphis in 1986 at a 38-percent reduction in our cash flow and an 83-percent reduction in our net income. Two issues in the Medicare Program which we would like for you to give some thought to. The DRG index needs to be looked at in terms of severity of illness. It does not take severity of illness into account. And those hospitals which get more critically ill patients with long-term chronic problems are getting into difficulty with the reimbursement.

Senator SASSER. Explain that to me.

Mr. CALTON. As an example, Senator, when I look at the DRG reimbursement for all of the diagnosis in our hospitals, the ones where we are losing large amounts of money are with patients who have various forms of cancer. Now, there are others where we do well. All I'm saying is that those things need to be balanced because you can't predict the mix of patients that a hospital will get in any period of time.

The second one, when the DRG reimbursement went into effect a requirement went into effect that says the physician attending the patient in the hospital has to sign a form which in effect swears that the diagnosis is correct. Our accounts receivable in the first 2 months of the DRG reimbursement program went up $5 million. Now we have been able to get that down to about $2½ million. But, we're losing the income from the money which is tied up in those things. And while the physician is required to sign the statement, the PRO organization comes right back and looks at the

coding of the diagnosis and confirms whether or not they are accurate.

We went through such a review recently and Methodist was given a 100-percent clean bill of health. We don't think that a test form is needed. The physicians have a great deal of difficulty with it because it says if they sign it and it's incorrect they're subject to being fined and go to jail.

MEDICARE TRUST FUND NEEDS HELP

The question has been asked what can we do to help the Medicare Trust Fund. Many things have been proposed. It's a complex situation. I'm not sure that I have the answer, but I do think that there are some things that need to be looked at very carefully. One of the obvious ones is to increase the FICA taxes. That is not popular with politicians. It's not popular with the public but obviously it is a source of funding.

A second possibility is to look at taxes on some products which are directly related to the state of health in this country. And I'm talking about alcohol and tobacco.

Senator SASSER. You must remember we are the second largest tobacco producing state in the union.

Mr. CALTON. I understand. If I took all of the things into account which would create problems when I say them, I'd probably never say anything. The third would be to extend the prospective payment system to all providers of health care. The fourth would be to look at eligibility for Medicare benefits, the use of some sort of means test so that the benefits bear some relationship to the financial well-being of the individual. The fifth would be to look at more controlled systems for the delivery of health services to beneficiaries of the Medicare funds and I'm talking specifically about PRO's and HMO's.

The next one I hesitate to say because I'm a firm believer in the free enterprise system. But, hospital cost in many cases is a direct reflection of what we have to pay for products and services. I think perhaps we ought to take a look at those, if for nothing more to see the impact they have on hospital health cost. I'm talking about the pharmaceutical industry, the high technology industries and some others.

The last one, I hesitate to say because it will get me into difficulty. But, the Federal Government operates a big health care system, including the Veterans' Administration hospitals. Perhaps somewhere along the way we ought to look at whether or not there is any feasibility of trying to combine some of these systems so that we operate more efficiently. I am not advocating doing away with the Veterans' Administration hospital system. I am simply saying that at any point in time where we have a capacity within the private hospital system in this country to meet some of the health care needs of the country, perhaps we ought to look at what everyone is doing and try to come up with a system that is equitable.

In summary I suggest that we stop looking at cutting out and controlling dollars and look together at trying to develop systems which will control the utilization of health services and I thank you for listening to me.

Senator SASSER. I thank you, Mr. Calton, for a very excellent statement. Mr. Sowa.

STATEMENT OF PHILLIP E. SOWA, PRESIDENT, REGIONAL MEDICAL CENTER AT MEMPHIS

Mr. SOWA. Thank you. Before venturing into my prepared statement I'd like to make two comments. I think in your prepared statement you mentioned that over the last 10 years the hospital industry has increased 452 percent in expenses yet just passed on 372 percent of that in-patient cost. Just as an interesting comparison the hospital industry during that same last 10 years has experienced a 1,900 percent in increase in medical malpractice insurance costs. So, these are some of the things that Mr. Calton didn't have an opportunity to express but there are some factors that really drive some of the cost increases that we see.

Second, my statement—while I agree with Mr. Calton on all but one of his comments—will come from a slightly different perspective. Our institution is a public institution. The Regional Medical Center at Memphis is a 450-bed public teaching hospital operated by Shelby County Health Care Corp. as a division of Shelby County Government.

I serve as a board member of the National Association of Public Hospitals, an organization that consists of 50 public hospitals and health hospital systems that serve major referral centers and hospitals of last resort for the poor in most of our Nation's large metropolitan areas. We appreciate the opportunity to participate in this hearing today representing a grouping of hospitals that have come to be known as disportionate share hospitals.

The national association was founded over 4 years ago with uncompensated care and disproportionate share hospitals as their most important priority. Virtually ever action we have undertaken within the last 4 years has had a goal of achieving and financing access to high quality health care for all of our Nation's citizens regardless of their ability to pay; the nature or severity of their illness. Your increased attention to these matters over the last several years has been essential because substantial changes in public and private reimbursement systems—ranging from Medicare Prospective Payment Systems to the growth of HMO's, PPO's and other alternative delivery systems—has significantly increased the pressure on disproportionate share hospitals.

COST SHIFT IS DISAPPEARING

The cost shift which had previously served to help subsidize care for uninsured or underinsured patients for all practical purposes is disappearing in the face of strenuous demands by all payers for cost containment. In our rush to contain costs and to curb hospital inflation we must recognize that not every cost previously shifted was due to inefficiency or waste. Many such costs are legitimate, including the cost of providing so called uncompensated care, the cost of educating future generations of health care professionals and the cost of biomedical research and essential preventive and primary health services.

Yet, even those essential services are increasingly being left by our system to be borne by local government, by taxpayers, by disproportionate share hospitals, by low income patients themselves or by no one at all. Most analysts now agree that there are several deficiencies in the present PPS methodology that contribute to serious inequities of the system for disproportionate share hospitals. These include among other factors the inability of the PPS System—that's the Prospective Payment System for the record—by itself to adequately account for differences in severity of illness for patients in certain DRG categories including patients with multiple diagnoses or who require multiple procedures.

TRAUMA CARE VERY COSTLY

I think this will validate Mr. Calton's comment. Our experience is we've just recently opened the trauma center. Trauma care is very costly care. We have—we think that we're providing, we know we're providing a valuable service to the community and to the region. However, the cost of that care is expensive. We billed the Medicare Program over $1.6 million in the first year of operation. That's the charges. Our reimbursement was less than $600,000 based on DRG's.

Another example of that would be the diabetic patient who requires amputation. DRG's do not accommodate for multiple diagnoses to the fullest extent. No. 2, differences in the costs incurred by hospitals in the inner city as opposed to cost in the suburbs including wage differentials and other factors. Third, differences in case mix among hospitals, particularly teaching hospitals.

No. 4, extraordinary circumstances experienced by hospitals during or after their PPS base year which may require appeals or exceptions. And fifth, the special situation and extra costs experienced by hospitals serving significantly disproportionate number of low income patients. Because we feel that members of the Congress clearly understand and in fact have attempted on several occasions to address these flaws in the PPS System we solicit your support to modify current budgetary language to assure the financial viability of this safety net hospital health care delivery system.

APPEALS AND EXCEPTIONS REFUSED

We have seen in the past the refusal of Health and Human Services to permit appeals and exceptions in many of the areas spelled out by Congress as requiring attention. The most notable instance represents the inaction on the part of HHS to enact the provisions created under the Prospective Payment System adopted in 1983. The legislation included an exception for disproportionate share hospitals and again required the Secretary to provide for exceptions and adjustments as deemed appropriate. This can be highlighted in the 1984 *California Redbud Hospital* case where Redbud Hospital filed suit against HHS challenging the hospital's initial payment rate under the new DRG system. On June 14, 1985, the court required that the secretary publish interim final rules by July the 1st, 1985 and final rules by October 1, 1985. Although HCFA appealed the decision, interim rules were published on July 1, 1985. These interim rules would allow hospitals on a case-by-case

basis to apply for an adjustment. They were also given a number of requirements with which they had to comply with in order to quality for this adjustment. However, no specific adjustment method was described in the interim rules and it might be said that the order was stayed by the Supreme Court.

CONCERN OVER THREE SPECIFIC PROPOSALS

The three specific proposals that we—of concern of the public teaching hospitals are as follows: The arbitrary freeze on DRG prices with no allowance for impact on inflation or advances in health care technology; No. 2, reduction in indirect teaching factor, a factor appropriately designed to cover the very real costs associated with the fact that teaching hospitals have a special mission and treat sicker patients; and third, the permanent freeze on payments of direct medical education costs.

When these three proposals are combined with the phase-in provisions of the present law, which continues to march to a single arbitrary national payment rate, their inequitable impact is magnified. Many hospitals will face not only unfair freezes in reimbursement but also dramatic reductions in actual payments from last year. More specifically the Regional Medical Center at Memphis calculates that these changes will impact to an amount greater than $1.5 million if these proposals are supported through legislative process.

The future looks even more bleak. We will not certainly be hurt by a tendency of other hospitals to pass along very expensive cases to them. I think this was illustrated in one of the previous testimonies. Many of the new reimbursement methods, such as DRG's and competitive bidding, pay on basis of an average case in a category and thus created an incentive of a nonmunicipal hospital to turn away patients with predictably more expensive illnesses than the average. Where can these patients go but the city or county hospital, the hospital of last resort?

The problem will be compounded by the disproportionate share of bad debt and charity that municipal hospitals already bear. Normally this burden is covered by State and local taxes, but these have increasingly become one of the focuses of cost-cutting efforts. The end result, Mr. Chairman, is that disproportionate share hospitals will not only become hospitals of last resort for the medically indigent but they'll also become hospitals for the elderly.

MUNICIPAL HOSPITALS RECEIVE LESS FEDERAL SUBSIDY

Finally, the proportionate Medicare payments in a municipal teaching hospital is about two-thirds of that to their nonmunicipal counterparts. For this reason municipal hospitals receive much less Federal subsidy in teaching programs than do their nonmunicipal counterparts. Unfortunately, municipal teaching hospitals have few, if any, plausible strategies for coping with these physical problems. While some municipal teaching hospitals, such as ours, are attempting to increase their private patient mix in their respective institutions, it is unlikely that most can compensate for reductions in Medicare and tax revenue by increasing their pool of private pa-

tients. This pool accounts for 10 to 25 percentage points less revenue than most nonteaching hospitals.

It seems inevitable that the quality of care and of the education programs in municipal teaching hospitals will suffer, perhaps severely, as a result of these financial pressures. I do not believe Congress wants to destroy America's teaching hospitals, those hospitals that treat our sickest and our poorest patients and train our future doctors, nurses and other health professionals.

Therefore, we would recommend that you, No. 1, amend the Prospective Payment System to halt the move to an arbitrary national rate by passing payments on DRG specific blended rates or by freezing the transition at a 50 percent hospital specific, 50 percent rational cost. No. 2, maintain the indirect teaching factor with some technical adjustment recognizing that that's needed to increase its accuracy as a surrogate for the real cost of teaching hospitals; and No. 3, reject the permanent freeze on direct medical education costs at least until the comprehensive assessment of gradual medical education is considered. No. 4, reject the arbitrary freeze on DRG prices.

TEACHING HOSPITALS HAVE CUT THE FAT

Mr. Chairman, American teaching hospitals have cut the fat. We simply cannot withstand cuts twice as severe as those faced by other hospitals. We ask your help in seeking relief from these unfair proposals. Thank you.

By the way as I was thinking, there is another alternative to raise some revenues and again we've looked at it locally. Other States have been very, very successful. I don't know whether it can legally be done nationally. The State of Pennsylvania, for example, has raised over $1.2 billion by their statewide lottery. This $1.2 billion has gone directly into social service funds that fund the aged.

The State of Maryland I think has had the same experience. I think they've raised—I know last year they put $200 million into their State coffers for other resources. Whether the Federal Government can do this, I don't know, but it's another resource.

Senator SASSER. I think you said, Mr. Calton, that hospitals had given away or provided $400 million in free treatment or unreimbursed treatment in Tennessee last year?

Mr. CALTON. In Tennessee last year hospitals provided three-quarters of a billion dollars in unreimbursed services.

Senator SASSER. That would be $750 million.

Mr. CALTON. $300 million of that represented services to patients who were unable to pay for the service. The other part of it was Medicare, lack of Medicare reimbursement, Medicaid reimbursement and so on.

Senator SASSER. So, if we could raise $1 billion with a lottery here, at least reimburse the hospitals for their unreimbursed treatment—you might be interested in knowing, Mr. Calton, that I voted for an amendment in the Senate this year to allocate a portion of the cigarette excise tax to the Medicare system as a way of raising additional funds. I don't think our tobacco growers in middle Tennessee have found out about that yet. But, I did that,

really I think, as an indication of how desperate I think the situation is becoming.

SETTING FIXED RATE CREATES PROBLEM

Mr. Sowa, you indicate in your statement that there is a tendency for other hospitals to pass along very expensive cases to municipal hospitals as I understood you. Does the Medicare reimbursement system encourage this tendency in your judgment?

Mr. SOWA. I think by setting a fixed rate on a particular diagnosis creates a problem. I think institutions, while they've not fully been implemented in the DRG process, the problem will be exacerbated as time goes on. The way I like to describe it best is there are going to be winners and losers. We're going to look at DRG's as product lines. If you look at a product line that you can produce or that you can care for at a cost less than you're being reimbursed, you're going to support that product line.

If you're going to look at a product line that is going to cost more than you're going to be reimbursed, you're not going to support that product line. I believe the system does support that concept, yes, sir.

Senator SASSER. Let me ask both of you this question. Can we diminish substantially the rate of inflation in health care cost and still deliver adequate health care to our population in your judgment?

Mr. SOWA. Well——

Senator SASSER [interposing]. I'm aware of many of the peculiarities that have caused a higher rate of inflation in health care costs than the CPI—aging population, high-tech medical techniques and expensive machinery and that sort of thing.

Mr. SOWA. I think there are several components to that problem. No. 1, the hospital—the hospital component of the CPI has been reduced by about 5 percent or 6 percent over the last 5 years. I think we presented a document to that. I think in part the DRG process has substantiated, has worked. I think hospitals and health care systems have to——

QUALITY HEALTH CARE STILL BEING RECEIVED

Senator SASSER [interposing]. Has it worked from the point of view of not only diminishing the rate of inflation of health care cost but also deliverying adequate or quality health care?

Mr. SOWA. I think in general I can say it would be safe to say yes. I think we're forced to look at the appropriateness of health care. We're forced to look at a gate keeper concept to insure that the patients are being treated at the appropriate level, to insure that the patient doesn't receive in-patient care when when in-patient care isn't required, to provide as many after-care services as possible. I think we had testimony to that earlier. Controlled aftercare services.

These factors will help curb the inflation of health care costs. I think in the past—at least the model that I envisioned—was that the hospitals was the hub and everything was directed out of the hospital. I think that's going to change. I think you really have to decentralize. I think we have to look at the primary care system as

by definition, the primary health care system. We have to look at education. Educating the population will help reduce the need for expensive esoteric health care needs based upon nutritional needs and nutritional education and so forth. I think that, yes, there are the opportunities. I think we are moving in the right direction.

Last, and I don't know whether Judge agrees with me on this, but I think that quite frankly, I think the Prospective Payment System is just a forerunner to something a little more complex, a capitation system for health care. I think that that too, given the appropriate safeguards to the safety net hospitals, can help curb inflation of overall health care costs.

Mr. CALTON. Senator, I think the answer to your question is yes. But, I would urge all of us to be very cautious about ever thinking that the cost of in-patient care for the individual will go down because I don't believe it will. There is just too much technology involved in the provision of in-patient hosptial care. I think what we have an opportunity to do, through alternative systems and other mechanisms, is redesign the way we deliver health care so that its overall cost is controlled.

HMO SYSTEMS ARE FORTHCOMING

Senator SASSER. When you were speaking in terms of capitation payments, what did you mean by that?

Mr. SOWA. I think the advent of HMO systems are forthcoming. I think California experiences—about 38 percent of all people insured in California are insured under HMO systems. Minneapolis, MN, is another example of that. I think it's in its infancy. I think it has to be developed much more comprehensively. I think we have to study the overall impact on the total health delivery system. That's why I urge caution as it relates to the public hospital system and where that leaves those patients that was referred to earlier by Ms. Stitt as falling through the cracks. There is that population out there that has a tendency to meet none of the requirements.

The patient that doesn't meet the Medicaid requirement, the patient that may not be old enough, the patient that happens to be in insured or under insured because of their occupation and that patient we have to be very careful of insuring quality health care.

OUT-PATIENT SURGERY INCREASING

Senator SASSER. Mr. Calton, under current Medicare policies we have seen a dramatic increase in in-patient surgery yet ambulatory surgeries have not increased at the same rate. Does this suggest anything to you?

Mr. CALTON. Senator, I don't know from what time period you're looking at the date of. But, everything I hear is that hospitals in the current year are experiencing a significant shift from in-patient surgery to out-patient surgery. To give you an example of that, at Methodist Hospitals of Memphis in 1985 thus far we have seen a seventeen percent reduction in our inpatient surgery and a 35 percent increase in our outpatient surgery.

Mr. SOWA. Mr. Chairman, we've experienced the same thing at the regional medical center at Memphis, particularly as it relates

to one specific division, gynecology, where in 1984 we had 847 inpatient procedures performed on an outpatient basis and 350 on an outpatient basis. In 1984–1985 we had 800 procedures performed on an outpatient and 430 on an inpatient basis. There is a switch.

Mr. CALTON. Let me tell you a little story. Not too long ago we had a man come to us from Missouri to have cataract surgery. He was 102 years old, a Medicare beneficiary, and he had his cataracts taken out in the ambulatory surgery unit and went home.

Senator SASSER. That's amazing. Gentleman, thank you very much for your contribution today. I think it's been very, very helpful and very illuminating. I may be calling one or both of you informally to get some advice on some Medicare matters in the future. Thank you very much.

I want to thank our next witness, Dr. Grobmyer, for waiting so very patiently. If you'd come forward. Dr. Albert J. Grobmyer has been on the active staff of the St. Francis Hospital here in Memphis since 1975. He is an instructor in surgery to family practice residency at St. Francis Hospital in conjunction with the University of Tennessee. Dr. Grobmyer is presently the president-elect of the Memphis and Shelby County Medical Society and he will assume the position of President next January. Of course, he's a member of numerous professional medical societies and received his medical degree from the University of Tennessee medical units here in Memphis in 1962.

Dr. Grobmyer, we very much appreciate your appearing here today and giving us the benefit of your views. Of course, we very much appreciate you waiting so patiently throughout all of this to give us your testimony. You may proceed and thank you.

STATEMENT OF DR. ALBERT J. GROBMYER III, PRESIDENT-ELECT, MEMPHIS AND SHELBY COUNTY MEDICAL SOCIETY

Dr. GROBMYER. Thank you, Senator. I'd like to make sort of an observation. My formal presentation may seem to be a compendium or perhaps a summary of much of the testimony that has preceded my presence here. That's not by design.

MANY PHYSICIANS FREEZE FEES

In March of 1984 the American Medical Association, in response to many of the same concerns which you have addressed today, requested that physicians voluntarily freeze their fees. In this community a survey conducted by the Memphis and Shelby County Medical Society revealed that some 200—of some 200 members polled 179 or almost 90 percent had frozen their fees. This voluntary freeze was supported nationally by 73 percent of physicians.

In many communities including Memphis, local medical societies had already developed programs to provide no cost interval health care to those who had sustained a loss of their jobs. Subsequently Congress mandated a price freeze for services rendered to Medicare beneficiaries. Starting in July of 1984 and proposed to run for 15 months this program incorporated as a charge base fees charged to Medicare patients in that 3-month period following the initiation of the AMA's voluntary program.

Participating physicians agreed to accept assignment for all Medicare claims until October 1, 1985. In the Memphis community some 18 percent of those surveyed had agreed to be participating physicians. Ultimately, a total of 199 physicians in the area were so designated. Of this total 115 were members of the Memphis and Shelby County Medical Society. Most physicians in the community elected to continue their option of accepting assignments on a case-by-case basis. I sense that physicians in declining to participate were expressing their own concerns over their inability to control their own spiraling practice costs.

The majority of this country's physicians have demonstrated a willingness to participate in a program of voluntary cost containment. There have been, however, no mandated price controls for those who purvey to physicians, their lessors, employees, and liabilities which attend physician-patient interactions.

To date, however, I am not aware of any restrictions imposed on Medicare beneficiaries, either in terms of health care access or in terms of quality of services provided solely as a result of the current price freeze. An anticipated response by physicians to a series of legislative fiats continuing pricing restrictions for Medicare beneficiaries would be one of cost shifting of incurred increases of practice expense to their self-pay and privately insured patients.

CONVENIENT ACCESS TO MEDICAL FACILITY MAY BE DENIED

The Prospective Payment System has brought with it an institutional reimbursement mechanism based upon a system of diagnosis related groups. Although many hospitals have increased revenues under the initial phases of this system other institutions will not be able to effect those economies of practice necessary to remain open. Consequently, the public may be denied convenient access to a medical facility in some geographic areas. A competition for patient access to those remaining resources will develop, particularly in the area of elective surgical procedures. Geographic relocation of physician specialists whose practices require an institutional setting will probably occur—another factor restricting health care access.

Hospitals are already reporting the effects of staff practice patterns on their profit or loss experience under the DRG regulations. Motivated by such financial considerations will hospitals attempt to measure staff an appointments by their economic efficiency rather than by their medical proficiency? Will hospitals sanction M.D.'s whose practices attract the sickest patients? Will hospitals decline admission to those patients with more complicated illnesses or whose DRG categories are less well compensated? Institutional pressures under DRG's may serve to decrease the income of non-surgical practitioners. Physicians certainly are apprehensive over these possibilities and recognize that such pressures may conflict with their traditional role as patient advocate.

ELIMINATION OF SALARIED INTERNS PROPOSED

Some authorities have suggested that in their attempts to minimize expenses some hospitals may propose the elmination of intern and resident physician as salaried physicians. In my opinion the

implications of such restrictions would be crucial to our current system of graduate medical education. The ability of medicine to attract the most skilled of our college graduates may well be compromised.

The cost of defensive medicine to our society is one which is borne by all who finance the health care industry in our country. Escalating malpractice awards and the attendant increases in premiums for professional liability insurance are significant components of the totality of such costs. Medical malpractice insurance losses are currently on the order of $2 billion annually. Surely, any governmental authority charged with exploring health care cost containment must give more than cursory attention to a problem which so directly influences health care costs and could impede system access for many.

The Professional Review Organizations, PRO's, are now operational. While I anticipate that their presence and the restrictions they impose may effect cost savings to the health system as a whole, I feel that some of their anticipated successes may be reflections of trends in utilization of services that antedated the PRO's. I feel it is important that physician-directed PRO's continue to be given preference in the awarding of such contracts.

The current denial rate for requested elective Medicare admissions by the Tennessee PRO is approximately 1.4 percent. Established guidelines relative to the intensity of illness determine admission criteria. This organization has not yet published any data relative to its impact on the incidence of Medicare admissions to Tennessee hospitals. I am concerned that the admission and utilization criteria are at times insensitive to the domestic and social circumstances of the beneficiaries creating a hardship for selected beneficiaries.

SYSTEM IGNORES SOCIAL FACTORS

I'd like to sort of comment. I think this is much the case that Mr. and Mrs. Lapides made to you, that the system at times ignores or is unable to appreciate those little nuances of social factors that are very important for a given patient.

The specter of DRG's for physicians is now being raised. This untested mechanism for physician reimbursement would establish global fee levels based upon diagnosis. The Center for Health Economic Research has developed a model to provide some information on how this might appear in application. Significant levels of variation within DRG groups would have resulted in financial losses for individual physicians, particularly in the treatment of nonsurgical illnesses. Such losses could not be compensated by an averaging process. Most physicians would treat only 2½ patients per year in any one DRG category and might encounter only 18 such DRG categories per year.

Such a system might create incentives for physicians to compromise or curtail services for patients. Needed speciality referrals might be postponed. The physician, as his patient's advocate, might defer to the interest of his institution. It seems somehow inappropriate for a system to allow a physician recompense for noncare. I'm unaware of any current evidence which supports the postulate

that DRG's for physicians can effect cost savings in health care while preserving its quality.

This year health care expenditures have grown at their slowest rate in 20 years. Physicians collectively are committed to providing the highest quality care at a reasonable cost. Physicians are willing to work with government in determining the best methodology in attaining these ideal.

Thank you for the opportunity to present my observations on these health care issues.

Senator SASSER. Thank you very much, Dr. Grobmyer.

[The prepared statement of Dr. Grobmyer follows:]

TESTIMONY

of

ALBERT J. GROBMYER III, M.D.

Mr. Chairman and members of this Committee: I appreciate the opportunity to share with you my observations and concerns with regard to certain issues in the administration and application of health care legislation as it applies to Medicare beneficiaries and the institutions and individuals who serve their health care needs. My commentary reflects my understanding or perception of some of the issues in question. As you know health care expenditures in this country are projected to rise to 12% of Gross National Product by 1990 and incrementally to 12.5% of GNP by 1995. Both government and providers are being challenged to implement cost-effective, state-of-the-art medical technology to an increasingly inveterate population whose "over-65" members represent 11% of our nation's citizenry. I am confident that the presence of this Committee's hearing here in Memphis is a responsible attempt to address these pressing social and economic issues.

In March of 1984, The American Medical Association, in response to many of these same concerns, requested that physicians voluntarily freeze their fees. In this community, a survey conducted by the Memphis and Shelby County Medical Society revealed that of some 200 members polled, 179 or 89.5% had frozen their fees. This voluntary freeze was supported nationally by 73% of physicians (A.M.A. survey). In many communities including Memphis, local Medical Societies had already developed programs to provide no cost interval health care to those whose had sustained a loss of their jobs. Subsequently Congress mandated a price freeze for services rendered to Medicare beneficiaries. Starting in July of 1984 and proposed to run for 15 months, this program incorporated as a charge base, fees charged to Medicare patients in that 3 month period following the initiation of the A.M.A.'s voluntary program. A new term "participating physician" then entered medical parlance. These "participating" physicians agreed to accept assignment for all Medicare claims until October 1, 1985. In the Memphis community some 18% of those surveyed had

agreed to be "participating" physicians. Ultimately a total of 199 physicians in the area were so designated. Of this total 115 were Medical Society members. Most physicians in the community elected to continue their option of accepting assignments on a case by case basis. I sense that physicians in declining to participate were expressing their concerns over their inability to control their own spiraling practice expenses.

Now I am led to understand that notwithstanding any other considerations, only those "participating" physicians will be allowed an increase in their approved levels of charges. The majority of this country's physicians have demonstrated a willingness to participate in a program of voluntary cost containment. There have been, however, no mandated price controls for those who purvey to physicians, their lessors, their employees, and the liabilities which attend physician-patient interactions.

If a continuation of the manditory freeze becomes a reality, I feel most physicians could more readily accept such a continuation if economic constraints on other segements of our economy also shared in some measure a reduction of Medicare's financial burdens. To date I am not aware of any restrictions imposed on Medicare beneficiaries either in terms of health care access or in terms of quality of services provided solely as a result of the current price freeze. An anticipated response by physicians to a series of legislative fiats continuing pricing restrictions for Medicare beneficiaries would be one of cost shifting of incurred increases of practice expense to their self pay and privately insured patients.

The advent of the Prospective Payment System has brought with it an institutional reimbursement mechanism based upon a system of Diagnosis Related Groups. Although many hospitals have increased revenues under the intial phases of this system other institutions will not be able to effect those economies of practice necessary to remain open. Consequently the public may be denied convenient access to a medical facility in some geographic areas. A competition for patient access to those remaining resources will develop particularly in the area of elective

surgical procedures. While such closings might curtail costs, one would hope that we would not emulate Great Britian where in 1979 over 150,000 people had been awaiting an elective surgical admission for over one year. Geographic relocation of physician specialists whose practices require an institutional setting will probably occur - another factor restricting health care access.

Hospitals are already reporting the effects of staff practice patterns on their profit or loss experience under the DRG regulations. Motivated by such financial considerations will hospitals attempt to measure staff appointments by their economic efficiency rather than by their medical proficiency? Will hospitals sanction MD's whose practices attract the sickest patients? Will hospitals decline admission to those patients with more complicated illnesses or whose DRG catigories are less well compensated? Institutional pressures under DRG's may serve to decrease the income of nonsurgical practitioners. Physicians certainly are apprensive over these possiblities and recognize that such pressures may conflict with their traditional role as patient advocate.

The cost of "defensive medicine" to our society is one which is borne by all who finance the health care industry in our country. Escalating malpractice awards and the attendant increases in premiums for professional liability insurance are significant components of the totality of such costs. It is beyond the scope of my commentary to explore in detail any of the several proposals which might temper the costs of these procedures or to address the restriction or abstraction of physician services in areas where malpractice insurance costs have become oppressive.

Medical malpractice insurance losses are currently on the order of 2 bilion dollars annually. Surely, any governmental authority charged with exploring health care cost containment must give more than cursory attention to a problem which so directly influences health care costs and could impede system access formany.

The Professional Review Organizations (PROs) are now operational. They play a pivotal role in the access of Medicare beneficiaries to hospital care. While I anticipate that their

presence and the restrictions they impose may effect cost savings to the health system as a whole, I feel that some of their anticipated successes may be reflections of trends in utilization of services that antedated the PROs. I feel that it is important that physician directed PROs continue to be given preference in the awarding of all such contracts.

The current denial rate for requested elective Medicare admissions by the Tennessee PRO is approximately 1.4%. Established guide lines relative to the intensity of illness determine admission criteria. I have reviewed the pre-admission denials made by our current PRO and have generally agreed with most of their determinations. This organization has not yet published any data relative to its impact on the incidence of Medicare admissions to Tennessee hospitals. I am concerned that the admission and utilization criteria are insensitive to the domestic and social circumstances of beneficiaries creating a hardship for selective beneficiaries.

The specter of DRGs for physicians is now being raised. This untested mechanism for physician reimbursement would establish global fee levels based upon diagnosis. The Center for Health Economic Research has developed a model to provide some information on how this might appear on application. Significant levels of variation within DRG groups would have resulted in financial losses for individual physicians particularily in the treatment of nonsurgical illnesses. Such losses could not be compensated by an averaging process. Most physicians would treat only two and one half patients per year in any one DRG catagory and might encounter only eighteen DRG catagories per year.

Such a system might creat incentives for physicians to compromise or curtail services for patients. Needed speciality referrals might be postponed. The physician, as his patient's advocate, might defer to the interest of the institution. It seems somehow inappropriate for a system to allow a physician recompense for "non-care". I am unaware of any current evidence which supports the postulate that DRGs for physicans can effect cost savings in health care while perserving its quality.

I have alluded to many areas whose composite interactions

weigh not only on the physician as a provider of services but also on his role as an advocate for the interests of his patients. There are several considerations which might serve to enhance the quality of medical services provided, to more efficiently utilize existing facilities or to reduce the overall expenses of the system.

1. Provide incentives for hospitals and physicians to function on a seven day week schedule.

2. Critically monitor proposals for "new beds", particularly in areas where surpluses are felt to exist.

3. Address the implications of our current tort system in the genesis of excessive costs via defensive medical practices and malpractice awards.

4. Develop further incentives for physicians to effect treatment programs in outpatient and office settings.

5. Recognize that excesses in the use of alcohol and tobacco products are responsible for the generating significant health care costs for Medicare beneficiaries.

Thank you for the opportunity to present my observations on these importanat health care issues.

Senator SASSER. In your experience, do present Medicare policies act as a disincentive for physicians to provide necessary health care services to Medicare beneficiaries?

Dr. GROBMYER. No, sir; not that I can appreciate.

PATIENTS ARE ACCEPTED ON CASE-BY-CASE BASIS

Senator SASSER. As a private physician what do you see is your responsibility for accepting Medicare patients on assignment?

Dr. GROBMYER. Well, in my personal practice I accept patients on a case-by-case basis. I find there are many patients of mine who are in a Medicare reimbursement setting who can afford to preclude my having to shift the cost of their care to my third-party paying carrier patients or my self-paid patients because that's exactly what evolves in this type setting.

In those cases where I perceive that it's going to be an economic hardship for the individual to respond by any financial reimbursement beyond what they have in terms of Medicare reimbursement, we accept the case on assignment. I do that at my own election with some understanding of the patient, hopefully of an appropriate knowledge of his financial circumstances.

Senator SASSER. Is there pressure on physicians to discharge patients early from hospitals as a result of new Medicare rules or procedures, in your judgment?

Dr. GROBMYER. There's been certainly no overt pressure in my practice or to my knowledge in my institution—I would presume in no institution in Memphis. The pressures are perhaps more perceived than real. I certainly think they are pressures which have potential to be implemented, perhaps somewhat subtly.

COST OF MALPRACTICE SUITS INCREASE HEALTH CARE COSTS

Senator SASSER. In your judgment do you think the cost of medical malpractice suits have been a significant factor in the increasing health care costs?

Dr. GROBMYER. Yes, sir; to the extent that physicians practice what I term defensive medicine.

Senator SASSER. Right.

Dr. GROBMYER. It's very difficult to put a dollar value on this type of thing. But, certainly in any patient interface one tends to provide the most exhaustive level of care for that patient in certain circumstances to avoid the stigma of cutting corners or of somehow obviating appropriate testing or consultation.

Senator SASSER. I'm constantly amazed at the explosions taking place in medical malpractice suits. Not too many years ago, I used to defend an occasional medical malpractice suit when I was in the practice of law. And we'd have maybe one or two a year. I was with a fairly large law firm in Nashville and did some of that. Apparently there's been an explosion of it in recent years. I hear from physicians all across the State and from hospitals saying that this is increasing their costs and the costs that they pass on to patients. I take it you would agree with that?

Dr. GROBMYER. Yes, sir; I don't think that anyone presumes that value judgment errors and other types of errors aren't made in physician and institutional patient relationships. I think we need

to accept that as reality. However, it seems that the system is somewhat cumbersome and perhaps unnecessarily expensive.

Senator SASSER. You might be interested to know I saw a report the other day that my former colleagues in the legal profession have now started to sue each other for malpractice. Someone said this is a form of professional cannibalism. I don't know. This may in the long run have more of a larger impact on limiting professional malpractice suits than anything else, I think. Once those in the legal profession get a taste of it they might change their attitude somewhat about it. Dr. Grobmyer, thank you very much.

Dr. GROBMYER. May I make one statement?

Senator SASSER. Yes.

Dr. GROBMYER. I had some suggestions.

Senator SASSER. I would like to hear this.

COST CONTAINMENT AREAS THAT MIGHT BE EXPLORED

Dr. GROBMYER. Relative to possible mechanisms or possible areas that might be explored in terms of pursuing your efforts of cost containment, one would be to provide incentives for hospitals and physicians to function a 7-day-a-week schedule. Two, critically monitor proposals for new beds, particularly in areas where surpluses are felt to exist. Address the implications of our current tort system, which you've already alluded to, in the genesis of excessive cost to be a defensive medical and malpractice awards. Develop further incentives for physicians to effect treatment programs in outpatient and office settings. Again, this has been alluded to previously. Recognize that the consequences of excesses in the use alcohol and tobacco products contribute to the generation of significant health care costs for Medicare beneficiaries. Thank you.

Senator SASSER. Thank you very much, Dr. Grobmyer. I appreciate you being here today and giving us the benefit of your views. I would like to thank all of those who participated in these hearings today. These hearings are very valuable and I think what we're seeing here is really the tip of the iceberg of what I think will be an ongoing national dialog in the next few years about the future of the Medicare system, what's to be done about it and also the future of health care generally.

In my judgment, that's going to be one of the great issues in the latter part of the 1980's and in the early 1990's and one that those of us in public life I think are going to have to devote a lot of our time and attention to. Those of you who have particular expertise in this field, as our witnesses have today, your views and viewpoints are very valuable to me and I'm sure those of my colleagues who will review this record and their staffs will share that view point.

So, I want to thank you very much for coming today. I'm reminded the record will be held open until September 30 for anyone who wishes to file an additional statement, either those who are present here or others who wer not present. And additional information can be sent to my office here in Memphis located in the Clifford Davis Federal Building, room 390, 167 North Main Street. Thank you and I declare these hearings adjourned.

THE BUDGETARY IMPACT OF RISING HEALTH CARE COSTS

FRIDAY, AUGUST 30, 1985

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Nashville, TN.

The committee met, pursuant to notice, at 1:30 p.m., at the Legislative Plaza, Nashville, TN, Hon. Jim Sasser presiding.

Present: Senator Sasser.

Staff present: Lance Simmens, legislative assistant.

OPENING STATEMENT OF SENATOR SASSER

Senator SASSER. First of all, I want to welcome all of you here and say that this is a field hearing being held under the auspices of the Budget Committee of the U.S. Senate.

This is one of a number of hearings I have held across the State of Tennessee over the past 2 years in an effort to identify emerging budgetary problems with regard to a number of very popular and much needed programs, and today we are going to be dealing with the rising problem of health care costs, which is one of the most critical issues facing the Congress. It will become increasingly critical in the coming years, and I predict that within a very short period of time there will be an intense national dialog over the question of health care costs, quality health care, and how to make that most affordable.

DEPLETION OF MEDICARE TRUST FUNDS

Now let me start immediately by saying that under current policies and using standard economic projections, the Medicare trust funds will be depleted before the end of this century. According to some actuaries, the Medicare trust funds could be depleted as early as 1993; according to others, using different economic projections, the Medicare trust funds will be depleted by approximately 1996. But, in any case, given our aging population and the rapidly escalating cost of health care, the Medicaid fund sometime in the decade of the 1990's is not going to be able to meet its obligations.

CONDITION OF MEDICARE TRUST FUND

Chart 1 (see p. 2) indicates what's happening to the Medicare trust fund. Starting in 1984, the Medicare trust fund will continue to accumulate budget surpluses up through 1992. By 1992, using the most optimistic projections, there will be a surplus of $76 bil-

lion in the Medicare trust fund. Then, as Medicare is hit by the population which continues to age, this surplus will begin to decline to the point in 1997 it's down to $17 billion, and by 1998 the fund, in essence, is depleted and will not be able to meet its obligations.

Now that is under moderate economic projections, and others indicate that difficulty could come much faster than that.

I think the recent congressional debate on the budget resolution clearly illustrated the administration's confusion over whether to include Social Security in its deficit reduction strategy. I steadfastly opposed efforts to do so. Medicare and Social Security are, in essence, trust funds. They are composed of contributions made by employees and by employers by way of payroll contributions, and neither Medicare nor Social Security are responsible for the Federal deficit, nor do they contribute to it. It is for this reason that I recently cosponsored legislation which effectively removes Social Security, which includes the Medicare Program, from the unified budget next year, and hopefully this will allay the fears once and for all of over 36 million Social Security and Medicare recipients who now receive benefits.

BENEFITS DOUBLED EVERY 5 YEARS

Chart 2 (see p. 3) illustrates that Medicare benefits have approximately doubled every 5 years. For example, in 1970 the Medicare fund was paying out $7 billion. By 1975 this had doubled to 14.8 billion, doubling again by 1980 to 35 billion, doubling again by 1985 to 70 billion, and finally, by 1990, almost doubling again to $120.8 billion.

The Medicare Program is celebrating its 20th anniversary this year. It provides a nationwide system of health insurance protection to individuals who are 65 years of age and older. And while the Medicare Program has been a very large success, inflation in the health care industry, combined with the rapid aging of our general population, presents serious problems for the program, as I indicated, before the end of the century.

Now I think the general population, and certainly everyone in this room, is aware that the cost of quality health care continues to rise at a truly astonishing rate. In 1983 the Department of Health and Human Services fo the U.S. Government estimated that $355 billion was spent on health cost in this country. That translates out to an average of $1,500 for every man, woman and child in our population.

Over the past 20 years, increases in the costs of health care services have exceeded price increases in the rest of the economy by a significant amount. In other words, helath care cost increases have been outdistancing the rate of inflation by an average of over 50 percent over a period of years.

HEALTH CARE COSTS RISE FASTER THAN INFLATION

Chart 3 (see p. 5) indicates the difference between the rate of inflation and the rate at which health care costs have been inflated. For example, in 1970, health care cost inflated 8.3 percent faster than inflation generally. In 1972 health costs inflated 9.2 percent

faster than inflation generally. In 1974, when we imposed wage and price controls, health care costs came down to the point where they were exceeding general inflation by only 1½ percentage points. When the wage and price controls came off, health care costs jumped back up in 1976 and 1977 to the point that they were outrunning the rate of inflation by 7.8 percent.

During years of very high inflation of 1979 and 1980, health care costs inflated only apporximately 2 percent higher than the general rate of inflation when we were running a general rate of inflation of about anywhere from 12 or 14 percent. But we see quality health care costs inflating again in 1982 and 1983, and nosing down just slightly in 1984, to the point that health care costs are now inflating about 4.8 percent, almost 5 percent faster than the rate of inflation.

Now the American Hospital Association, which compiles detailed records and statistics on the Nation's community hospitals, in its latest survey indicates that community hospital expenses for 1983 amounted to $120 billion. This is the cost of operating community hospitals, $120 billion. And this represents an increase of 452 percent in the expense of operating hospitals over the preceding 10 years.

The average cost of spending a day in the hospital as a patient in 1983 was $391, representing an increase of 372 percent over a period of 10 years.

But we are at a point in our planning where were must address the problems of health care costs and the emerging problems of the Medicare System. When you are dealing with tens of millions of people, and with demographic factors, you must plan very far in advance, and I think now is the time to anticipate the shortfall in Medicare funds that will occur in the 1990's and now is the time to start planning ahead for that, and we must all work together—hospital administrators, doctors, beneficiaries, home health advocates.

It's not the purpose of this hearing to cast blame on any one particular group. The purpose of this hearing is to face the current realities of increasing health care costs and explore ways in which we can effectively deal with them. This hearing, is I think, a beginning, and we'll begin by hearing testimony from beneficiaries of the Medicare System.

Our first panel of witnesses will consist of individuals who are familiar with the Medicare system. Our first witness is Mr. Gordon Bonnyman who, for the past 12 years, has been a staff attorney with the Legal Services of Middle Tennessee. Mr. Bonnyman received his law degree from the University of Tennessee in 1972, and a bachelor's degree from Princeton University in 1969. He is a member of numerous professional associations, including the Tennessee Bar Association and the Nashville Bar Association.

Come forward, if you would, Mr. Bonnyman. And Mrs. Leech—is Mrs. Leech in the room? Mrs. Leech, I understand that you are just recently out of the hospital, so rather than asking you to give testimony today, we will listen to Mr. Bonnyman, and then I'll ask you just a few questions, if I may.

I'm advised, Mrs. Leech, that you are not feeling well today, and we probably ought to go ahead and begin with you, and so I will do

that. Would you pull that mike just a little closer to her, Mr. Bonnyman.

Mrs. Leech, would you be good enough to tell us for the benefit of the record what medical problems you have.

STATEMENT OF BEATRICE LEECH, MEDICARE RECIPIENT

Mrs. LEECH. Last time I went to the doctor, I was suffering with my back, and it was affecting my legs, and I was having severe headaches, and the doctor told my husband to bring me out there.

Senator SASSER. How often—excuse me, go ahead.

Mrs. LEECH. For several years I've had a number of operations including two cancer operations, colon operation, and a number of things. After he examined me, he said that I needed to go in the hospital for some tests. I was dehydrated for one thing, and that my back, he wasn't sure that was from the cancer of the spine or what.

Senator SASSER. You do have a cancer of the spine?

Mrs. LEECH. Yes, sir.

Senator SASSER. Now what is your age, Mrs. Leech?

Mrs. LEECH. Seventy-two.

Senator SASSER. And how often do you have to go to the hospital?

Mrs. LEECH. The last year I was in there a number of times. I've forgotten. This year I haven't been in there yet. This is the first time I've been in there this year.

HOSPITAL ADMITTANCE REFUSED

Senator SASSER. Would you tell us, please, what happened the last time you tried to go into the hospital?

Mrs. LEECH. Well, the doctor called Medicare in Memphis, and, of course, I don't know what he told them, you know, was wrong, but that I needed to go. And they refused. He called them twice.

Senator SASSER. Did your doctor think it was necessary for you to go into the hospital?

Mrs. LEECH. I told him I'd rather not go to the hospital, and he said, "Well, I think you should, I need to make some tests."

Senator SASSER. And did Medicare then prevent you from going to the hospital on this last occasion as your doctor had recommended?

Mrs. LEECH. They refused to.

Senator SASSER. Do you know why they refused to let you go to the hospital?

Mrs. LEECH. I don't know. I didn't discuss it with my doctor.

Senator SASSER. Now, do you have a supplemental insurance policy, Mrs. Leech?

Mrs. LEECH. My husband has a group insurance with Paul Revere through Avco. They have to have an EOB for Medicare stating whether they are paid or denied before Paul Revere will pay. They'll pay what Medicare doesn't pay.

Senator SASSER. Well, let me ask you this question, Mrs. Leech. What would be your circumstances or what could you do if you had not had this supplemental insurance policy?

Mrs. LEECH. I have no idea.

Senator SASSER. Would you have been able to pay your additional medical expenses that Medicare would not pay?

Mrs. LEECH. No way.

Senator SASSER. In other words, without the additional medical policy that your husband had, I assume as a result of his place of employment or something else——

Mrs. LEECH. He's on disability himself.

Senator SASSER [continuing]. You would not be able to pay the additional medical expenses you incurred outside of the Medicare system?

Mrs. LEECH. No, sir.

MEDICARE COVERAGE INADEQUATE

Senator SASSER. Well, Mrs. Leech, would it be your observation then that the Medicare system is not adequate or not sufficient to cover the needs of elderly people who are very sick people who need expensive medical care and treatment, admission into hospitals?

Mrs. LEECH. Undoubtedly it isn't.

Senator SASSER. You don't think it's sufficient to cover your needs, Medicare is not?

Mrs. LEECH. I mean they are not. They refused it this time.

Senator SASSER. They refused it this time, and refused to allow you to go into the hospital that had been recommended by your doctor?

Mrs. LEECH. Yes.

Senator SASSER. Well, Mrs. Leech, I think you have told us what we need to secure from you today, and I thank you very much for being here. And in view of your condition, if you wish to leave and go back home, why, please feel free to do so. We appreciate your being here.

Mrs. LEECH. Thank you. I appreciate it.

Senator SASSER. Anything else you'd like to say to us before you leave?

Mrs. LEECH. Well, the only thing is, like I said, I have been in and out a number of times, and had several operations, and I still have trouble with my back and with my legs, and this cancer of the bone is under control at this time, but I had already had a breast operation of cancer.

Senator SASSER. I see.

Mrs. LEECH. And a colon operation a number of years ago.

Senator SASSER. Did you have cancer of the colon also?

Mrs. LEECH. No; they hadn't found it yet. They are still going to make some more tests.

Senator SASSER. I see. Are they going to put you in the hospital for these tests?

Mrs. LEECH. Well, I was supposed to go to the doctor's office today for him to check me over again, and he said they might have to make some more tests on me.

Senator SASSER. I see. Well, thank you very much, Mrs. Leech. We appreciate you being here today.

Mrs. LEECH. Thank you.

Senator SASSER. Mr. Bonnyman we are delighted to have a Princeton Tiger with us here this afternoon, and why don't you proceed with your testimony.

STATEMENT OF GORDON BONNYMAN, STAFF ATTORNEY, LEGAL SERVICES OF MIDDLE TENNESSEE

Mr. BONNYMAN. Thank you, Senator. I should say that I'm not a Medicare beneficiary, and the only reason why I'm here is because I have clients in my federally assisted, legal services program, have a number of clients, who are Medicare beneficiaries who are elderly and in ill health, and a couple of those individuals have particular cases whose circumstances, I think, will illustrate the shortcomings of the Medicare Program. Unfortunately, they are so ill that they were not able to be here physically today.

Senator SASSER. Let me interrupt. Can you hear Mr. Bonnyman in the back of the room all right?

MEDICARE PROMISES BEING BROKEN

Mr. BONNYMAN. Let me just say initially that on the basis of lengthy experience, not only myself but of my colleagues, of observing the deficiencies in the Medicare Program, if we think back 20 years ago, we think of the promises that were made to the elderly on behalf of the Medicare Program, you can only fairly say that those promises are being broken today by the deficiencies in the program, that the program hurts the elderly in its deficiencies, hurts their health, to the extent that it not only fails to maintain those promises, but it also humiliates them. And let me illustrate that contention with a couple of individual cases.

One is the case of a very brave lady named Patricia Foster who is living in a Metro retired teachers apartment here in Nashville. She was disabled 10 years ago, very serious heart attack. She has emphysema and serious breathing difficulties, asthmatic, and is oxygen dependent on a daily basis, and she could not be here, in fact she was just released from the hospital and was too infirm even for us to get her testimony by videotape.

She receives $349 a month in Social Security benefits, which means that she is too rich to receive Medicaid at that paltry amount of Social Security benefits, which is not far below the national average. She doesn't have enough to get the protection that Medicaid would afford to fill in the gaps in the Medicare Program. So she's wholly dependent on Medicare for her health care.

Several weeks ago she started having particular problems breathing and needed to go to the hospital. She knew that when she went to the hospital with nothing more than Medicare, she would have to put up a $400 deposit to cover the Medicare deductible for hospitalization. She didn't have $400, $349 a month, it's easy to understand why she wouldn't. She's very typical that way. She's also very typical in that she, as a senior citizen, is extremely proud, feels badly about accepting credit or charity, has lived all of her life paying her way through the world, and so she simply didn't go to the hospital. And by the time she finally went to the hospital in emergent condition, she had developed pneumonia, and she was in congestive heart failure. In other words, this $400 de-

ductible that Medicare requires before it starts covering hospitalization had endangered this person's life, and that is no exaggeration, because of her very typical reaction of "If I can't pay I'm not going to go."

Now there are in fact Federal regulations which say that she could be admitted anyway, but that's no solace to all of the senior citizens out there who say "If I can't pay it I'm not going to go."

She also has nine prescriptions a month, which means that her prescription drug bills approach $100. Again, it is not unusual. I see it all the time, and so do other people who deal with Medicare patients. It's not unusual to see elderly people with drug bills that run $100 to $200 a month, and that's to come out of a $350 a month Social Security check.

Mrs. Foster indicated that last year she had a very difficult time coming up with the $75 to meet the deductible requirement for part B, which provides coverage for physician services. So Mrs. Foster I think is one illustration. I wish that she were atypical, but she's not.

I have another client in much the same circumstances, Mrs. Emily Shoemate who lives in a highrise for the elderly here in Nashville, a widow who is also a very very brave lady. She took care of her husband who was a stroke victim for 5 years in their home. She also is oxygen dependent, has very serious asthma. She has an income—she's a good bit more wealthy than Mrs. Foster, because she has $363 a month. She also is therefore deprived of Medicaid and is totally dependent on Medicare. Her drug bills run $69 a month, and when I was recently talking with her about how she did that, she said, "Well, I just don't take the medicine that I'm ordered to take. Instead of taking four pills a day, I take two pills a day." Any physician can tell you that there is the concept of a subtherapeutic dosage which means if you don't take a certain amount, you might as well be taking none at all, or in some cases it could actually be harmful.

MEDICARE PROGRAM HAS BROAD GAPS

So these are the kind of choices that persons who were not senior citizens were promised 20 years ago, to be taken care of by Medicare. Those are the kinds of choices they are being forced to make. And when you talk to both Mrs. Foster and Mrs. Shoemate, a common theme that comes out is not only the hurt but even before that is the humiliation, the fact that they can't pay their bills, know they can't pay their bills and know that they are not going to get the care they need if they can't pay the bills on their own. And Medicare was created with the promise that it would cover those bills.

Our program puts out a guide to Medicare supplement insurance, MAZE,[1] as we call it. It's very difficult to sort out all the competing policies of a Medicare insurance supplement package that will fill those gaps. As you are probably aware, Medicare now covers less than half of the personal health costs of the people that

[1] "A Guide to the Medicare Supplement Insurance Maze," 1985, Beverly Delores Fisher and Adinah Robertson, Legal Services of Middle Tennessee, Inc., Nashville, TN. Retained in committee files.

is purports to cover. So when you talk about the gaps in the program, the gaps are broader than the coverage itself.

Because we put out this supplement we get calls all the time. The response to this supplement has been very—this guide to supplement insurance—has been very poignant. We had, and this is typical, we had a lady last week who called, for example, and talked to Adinah Robertson, the person who puts together this guide, and it was only after 45 minutes, in which she discussed all the money that she was paying out of pocket for her insurance, that she revealed that she paid for this Medicare gap insurance by going without food for the last 2 weeks of the month. And Adinah said, "How do you do that?" And she said, "Well, I lie down on the couch and I try not to move around very long, and by the end of the month I'm not able to move around very long, and that's until I get my check the next month, and that's so I can pay for my insurance, because I know I can't get in the hospital, because I know that I don't have $400."

Senator SASSER. Who is this woman, Mr. Bonnyman?

Mr. BONNYMAN. This is a woman who's name we were not permitted to give out because she was too embarrassed. As I say, it was only 45 minutes into that conversation that she even revealed this to Adinah. Adinah then talked to her doctor, and her doctor said, "I've noticed that her potassium level was going on down and her health status was very poor, and she never revealed that to me," and so she categorically refused to come here today, but we did get permission to cite that. We got another card two weeks ago.

Senator SASSER. Is Adinah one of your legal assistants?

Mr. BONNYMAN. She is a paralegal, and she's one of the people who put together this guide.

Senator SASSER. Is this a local publication, your guide there?

Mr. BONNYMAN. It is, yes, sir.

Senator SASSER. We'd like to get a copy of that.

Mr. BONNYMAN. Be pleased to.

Senator SASSER. And attach it to your testimony today.

Mr. BONNYMAN. Fine. She got a card the other day asking for a copy of the guide. It had been featured in a syndicated supplement column statewide about aging problems. We got a card, and the person closed it by saying, "I'm weighted down by policies, dash, in fear." And I think that's what is so cruel, because you not only have people like Mrs. Leech who need the care and are not getting it, but the burden that hangs over every elderly person and every Medicare recipient is the fear. They may not be sick, but they know that they may get sick, and they know increasingly that Medicare is simply not going to be there when they need it. So on behalf of our clients, we very much appreciate your leadership on this, and hope that you'll do what you can to start filling some of those gaps and alleviating some of that fear.

Senator SASSER. Thank you, Mr. Bonnyman. And I gather that it's your conclusion that Medicare has in essence reneged on the expectations or promises made to the elderly 20 years ago. Is that a fair summation of your testimony today?

Mr. BONNYMAN. That's absolutely fair. And I think the situation is getting worse.

DRG REASONABLE CONCEPT

Senator SASSER. Let me ask you a couple of technical questions. In your experience what is your impression of the diagnosis related group system, the so-called DRG, that was instituted under the Medicare system last year?

Mr. BONNYMAN. I think the DRG concept is a reasonable concept, and if I may interject something here Senator, sitting back in the audience it was difficult to review your chart where you went over the inflation rate. And having been aware that that was difficult for the audience, I would just like to reinforce the point that you made——

Senator SASSER. Coming down here, the rate of inflation in 1983–84 has come down from 7.1 to 4.8.

Mr. BONNYMAN. That's correct. I think to put that nto perspective, that is, of course, percentage points, which, when you compare—maybe a more graphic way of putting that, we are talking about a rate of inflation over that period that, with the exception of that dip during the wage and price controls, was two to three times as much as the rate of inflation generally.

Senator SASSER. Health care costs were running 50 percent, on the average, ahead of the rate of inflation.

Mr. BONNYMAN. Right. And that just wasn't clear, I don't think, back in the audience. So I just wanted to make that point. DRG's I think are a reasonable response to beginning to get ahold of some of the inherently inflationary aspects of both Medicare and the health system as a whole. What I think is inexcusable about—and I can't avoid using some fairly strong language, because I see this kind of suffering all the time—what is inexcusable about the adoption of DRG's for Medicare patients only is that it singles Medicare patients out for discrimination by providers. And what it means is that—and I was talking to a hospital administrator yesterday who was saying, you know, "We are one of the few hospitals that likes to take Medicaid patients and we are going to become one of the few who will take Medicaid patients." What you are seeing with DRG's, you are going to find in the future that some homes and many hospitals will simply refuse to treat those particular diagnoses which are not lucrative. And if DRG's are a good idea for the elderly and the disabled, then they should be a good idea for everybody. Don't single out. If this is a reform that is justified, and I think that it is, then it should be applied more generally.

What I think is inexcusable about the Medicare Program is that it is behaving just like the private insurance companies, just like the big employers that are saying, "We are only looking out for our own budget, our own bottom lines, and without any regard for the health of the people who are dependent upon our program."

Senator SASSER. Would you recommend then that private insurance companies and large employers move in the direction of the DRG system?

Mr. BONNYMAN. I believe that will happen regardless of what we do. But I think that what is required is that the Government look at the effects of the system as a whole, and say that as these various groups go to DRG's, or whether they use DRG's or some other method of cutting back the amount of money going into a previous-

ly inflationary system, what is going to happen to the people, whether they are on Medicare, which only covers less than 50 percent of their budget for health care, or whether they are on these other programs, who's going to fill those gaps? And isn't that, after all, the kind of promise that was behind Medicare to begin with? And that's the kind of questions that is not being asked, at least I haven't before these hearings heard it being asked by people in the Federal Government, quite often enough.

I'm aware that you've been asking the question and hope that you will continue to, but my purpose is not to criticize DRG's per se, but to say, you've got to be aware of what happens to people like Mrs. Leech when you implement a system like DRG's, and you've got to be concerned about that.

Senator SASSER. I think you get mixed opinions on DRG's, and I think the most objective analysis would be that, from the testimony we've been getting, is, yes, DRG's are effective in reducing health care costs to a certain extent. If there is a problem with the DRG concept, it is that it treats a whole range of patients in the same way. It doesn't take into consideration an individual patient's need or individual patient hardship. On balance, it has been effective in reducing health-care costs, but there may have been some deterioration in the quality of health care delivery as a result of DRG's. That appears to be the general consensus.

IMPACT OF MEDICARE POLICIES ON INDIGENTS

Let me ask you a very open-ended question, Mr. Bonnyman. What is the impact of the present Medicare policies, in your judgment, on the delivery of health care to indigent patients?

Mr. BONNYMAN. It's very adverse, and I think just by way of definition it's important to understand what we mean when we say indigent, because a lot of people who think they are indigent or poor in the normal sense, if they have a large enough automobile accident or injury or illness, will find themselves unable to meet the cost of care. So if you are talking about the people who are unable to meet the cost of care, it's extremely serious, because the effect of DRG's and Medicare policy generally, which is to say we are going to put less money into the system, is that it makes it less possible and less attractive in a competitive marketplace for providers who are competing with each other for lucrative patients to factor into those lucrative patient bills the cost of making up the Medicare shortfall.

If you are running a business, and that's all health care is today, unfortunately, it's a business, like any other business, you've got to keep the lights on, you've got to keep the doors open. If you don't get enough out of your Medicare patient you are going to spread that cost over to somebody else, and if you've got an indigent patient who is not able to cover all that cost, you are not going to treat them at all.

And so what we are seeing is lots and lots of very graphic horror stories of people who are not on Medicare or they don't have other coverage, the coverage they have which is inadequate, simply are not getting care. And I'm talking about life-threatening emergencies. So again I go back to the idea that you've got to think of the

health care system as a system, and broaden the perspective beyond Medicare to say if we push on this part of the balloon, what's going to happen in the other end of the balloon? Medicare is the largest purchaser of health care in our country. You don't just tinker with that system and expect it to have no consequences on the other parts of the system. So you've go to be aware that it's having a very adverse effect on other areas of the system.

SIGNIFICANT NUMBER NOT GETTING NEEDED CARE

Senator SASSER. Do you find a significant number of people falling through the cracks with regard to heatlh care, whether by Medicare, Medicaid, and so forth, people who are just not getting medical care or the quantity of medical care that they need?

Mr. BONNYMAN. Very significant number, and there's been interesting research in Tennessee in the past year that shows that the number of people who were uncovered, that is, their insurance—they didn't have any third-party coverage, because they work for a minimum wage employer who didn't provide it, they couldn't afford to buy it, because they had bad health problems and no one would insure them, that group—they did a household sample in Tennessee, they found that of the population in that group that had been ordered by a doctor to go to the hospital, nearly half had not attained hospital care, some had been turned away, many others had not gone simply because they knew they couldn't afford it. What I see is the individual tragedies which are buried in those statistics. That was only focused, incidentally, on the perhaps 15 percent of Tennesseans who had no coverage at all. And many of those are middle class, incidentally, but they have very serious illnesses and are not insurable. What that ignores is another 15 percent who are underinsured because they can't afford the premiums, the coverage is not good. So you are talking about perhaps a third of Tennesseans who lack of fundamental guarantec of access to needed health care, even in life-threatening situations.

Senator SASSER. Mr. Bonnyman, thank you for appearing here today, and we appreciate your efforts and the efforts of legal services on behalf of many unfortunate people that otherwise I think would get no consideration.

Mr. BONNYMAN. Thank you very much. Senator, Mrs. Leech asked me to pass a document to you, if I may.

Senator SASSER. All right. Sure.

Mr. BONNYMAN. And I'll also give you the guide to the Medicare supplement.

Senator SASSER. If you'll just put the medical care supplement on the reporter's table there, he'll note it as an exhibit to your testimony.

Mr. BONNYMAN. Shall I pass this up?

Senator SASSER. Yes, please.

Mr. BONNYMAN. Thank you very much.

Senator SASSER. Thank you very much.

OK. Our next panel consists of representatives from the hospital industry. Mr. Ira Lane, the president of the Tennessee Hospital Association. Mr. Lane has previously served as the association's chief executive officer. Come on up, Ira, and take a seat here.

Mr. Lane serves on numerous advisory boards including the Southeastern Hospital Conference, is currently in the process of writing two books on health care, and they ought to be real hot sellers, Ira. All the attention is being focused on health care this day. I might say by way of qualification that Mr. Lane recieved his bachelor's degree in business administration from Mississippi State University back in 1950, and has taken several health care administration courses at the University of Michigan and Cornell, and he'll be joined on this panel by Mr. John Stone.

Mr. Stone is currently the director of hospitals for Metropolitan Government here in Nashville, and serves as chief executive officer of both General Hospital and Bordeaux Hospital. He received his master's degree in health care adminsitration from George Washington University in 1968, and he holds a bachelor's degree from Austin Peay University.

Gentleman, I'd like to welcome you both here today, and we'll begin with you, Mr. Lane, if you would, please.

STATEMENT OF IRA M. LANE, JR., PRESIDENT, TENNESSEE HOSPITAL ASSOCIATION

Mr. LANE. Senator, we appreciate the opportunity of being here. We commend you for holding these hearings and getting information that can be used to improve the lot of the elderly and the poor which we are here very concerned with.

I'm here representing 167 hospitals in the State of Tennessee. We note that there are tremendous changes that are sweeping the health care industry at both the State and the national level. We are in a period of rapid transition that is shaping not only the way health care is delivered but also how health care is financed in both the private and public sectors. We are experiencing a revolution in health care unparalleled since the adoption of the Medicare/Medicaid program in the early sixties.

President Johnson believed and Congress agreed that health care is a basic right of every American, and the Medicare and Medicaid programs were adopted to assure that right for the poor and the elderly.

In introducing these programs to the American public, President Johnson said, and I quote, "The Great Society asks not how much but how good." Two decades after the introduction of the Great Society program, we no longer ask how much good can we do, but how much good can we afford to do. Have we reached a point where our ability to provide health care has outstripped our ability to afford that care? It is an ethical and moral dilemma for all of us working together to resolve.

INFLATIONARY SPIRAL BROKEN

However, we have good news. The inflationary spiral of the 1970's and 1980's has been broken, and encouraging cost containment results have been achieved in both the private and the public sector. Between 1975 and 1982 annual hospital expenditures advanced at an annual rate of 16.2 percent. That rate had dropped to 10.2 percent by 1983, and only 4.6 percent in 1984, and that continues through the first 8 months of 19——

Senator SASSER. This is reflected in our chart, I think. And is this a rate of inflation in hospital cost over and above the rate of inflation for the general economy?

Mr. LANE. This is the percentage increase of the aggregate over the previous year.

Senator SASSER. In hospital cost?

Mr. LANE. In hospitals only. Only. Total admissions fell sharply in 1984. A 4-percent decline in 1984 admissions was largely driven by a decline in admissions of patients under age 65. But admissions of patients age 65 and older also declined. Under age 65 admissions fell 4.5 percent in 1984. A gradual decline in admissions of patients over age 65 started in the third quarter of 1983, and 1984 was the first time admissions for this age group had declined for a full year.

Admissions of patients age 65 and over increased 4.7 percent in 1983, and averaged 3 percent or better for the last 10 years, but in 1984 declined 2.9 percent.

A survey of our members indicate the Tennessee hospital occupancy rates have declined in the last 2 years falling from an average of 69 percent in the period October 1983 to 62.7 percent in September 1984. Changes in private health benefit plans, which are part of the deductibles and co-insurance, advances in technology which permit more outpatient treatment, and changes in medical practice patterns are the three major factors which added impetus to declines in hospital admissions of private patients. The implementation of professional review program also has affected that admission rate.

The length of stay nationally had been reduced by 5.1 percent at the close of 1984 to only 6.5 days. Similarly, in Tennessee the average stay for all patients fell from 6.4 in the fourth quarter of 1982 to 5.7 days at the close of the third quarter of 1984. In Tennessee the average length of stay for the Medicare patient dropped from 8.33 days in 1982 to 7.02 days in 1984, a reduction of 12.4 percent. Full time equivalent personnel employed by hospitals nationally has dropped drastically. Over 145,000 employees have been discharged. Between 2,500 and 3,000 have been laid off in Tennessee.

All of these indicators are good news to those interested in hospital cost containment. They show that hospitals are responding to public demand and the discipline of the marketplace.

MEDICARE CUT $11 BILLION

The 1986 Budget Reconciliation Act includes an $11 billion reduction for Medicare over the next 3 years and hospital payment levels have been frozen at 1985 rates. This so-called freeze adds up to an actual reduction in Medicare spending for hospitals of $435 million. These reductions are heaped upon the previous reductions in the last four years amounting to $27.4 billion. Furthermore, beginning with the Omnibus Reconciliation Act of 1981, Medicaid payments have been reduced respectively for the 3 years 1981, 1983, and 1984, by 3, 4, and 4½ percent. The proposed budget for Medicaid calls for an additional $1 billion reduction for fiscal year 1986. This is a particularly disturbing trend in light of the growing

problem of medical indigency in our State and the Nation as a whole.

Unless we are careful, we may ultimately cut too deeply into the fabric of the social safety net for many older citizens and the poor. More than 330,000 Tennesseans, mostly women, children, and retired persons, have no health insurance. Hospitals traditionally have taken care of these unmet needs through direct charity and by absorbing bad debt. Last year Tennessee hospitals provided in excess of $300 million in charity care, and add to that in excess of $400 million because of under-reimbursements from both the State and Federal program for Medicare/Medicaid.

Senator SASSER. What was that figure again, $300 to $400 billion?

Mr. LANE. $300 million of charges for indigent care.

Senator SASSER. That were unreimbursed.

Mr. LANE. And $400 million under Medicare/Medicaid Program of charges made that was not paid. If you look——

PAYING PATIENTS ABSORB COST

Senator SASSER. Who absorbed that cost, Ira?

Mr. LANE. Senator, this is a form of what we call cost shifting or sick tax that's charged to the paying patient for charges not collected from the other patient.

If you'll look at the end of my testimony, you will see a disturbing trend in the amount of uncompensated care, going, for the statewide Tennessee totals, from $427 million in 1981 to $721 million in 1983, or a 69-percent increase in that 2-year period. 1984 data, which will not be available until October, will show an even greater increase in that total.

When we analyze it, the payment program and the Medicare Program has been a good program, and we hope that it continues, but when we analyze the charges that are paid for services rendered, based on statistics for the entire Medicaid load for the year 1982, 6.4 percent of the charges were paid by the patient, 57 percent were paid by Medicare, and 36 percent were paid by neither party and had to be cost shifted.

The ability of hospitals to sustain high levels of uncompensated care is being rapidly eroded because of low profitability in many services and by increasing demands for discounted services from health maintenance and preferred provider organizations.

Going across the State of Tennessee this week and next week is a number of companies who are demanding discounts from hospitals in forming new preferred provider organizations. What will happen from that is the profit previously made on those patients no longer will be there to pay for the indigent patient. So consequently, we are afraid of our ability to continue providing that level of care.

HOSPITALS ENTERING NEW ERA

Clearly, hospitals have entered a new era, and, as predicted, there will be winners, there will be losers, as hospitals take a more businesslike approach to providing health care in a competitive market. Some hospitals will surely close, but many others will survive by closing unprofitable services, by controlling the amount of

uncompensated care, and by adopting market strategies to provide alternatives to inpatient hospitalization.

We predict that 50 percent of the surgery formerly done in hospitals will move to an outpatient basis. Even the lens transplant operation that previously on the Medicare patient had been 3 days in the hospital is now being done as an outpatient, which saves in the cost.

In this arena the question arises, who pays for the poor? It is a question that strikes at the heart of our social consciousness. The answer, of course, is we all do, and we should be concerned. The real question is how are we going to pay? It is the position of the Tennessee Hospital Association that uncompensated care is the responsibility of society as a whole, not just of the sick patient who comes to the hospital and receives an extra tax. The Federal Government has a special responsibility both to the poor and elderly, many of whom are also poor. Already, however, budget cuts and payment freezes have affected both Medicare and Medicaid. Continued budget cuts may make political winners but our poor and elderly will be the losers.

In looking at some of the solutions, Congress should enact legislation to allow the DRG rates to take into account patient condition, the severity and that you referred to earlier, and I think those are under study and we encourage the Congress to continue your studies so that the hospital that takes the high intensity patient and the serious patient will get its cost for that care.

The patient admitted with a primary diagnosis of diabetes may be subsequently found to be suffering from hypertension and heart disease. These conditions complicate the case and require more resources for adequate treatment. Under the present system, that's not properly addressed, and we hope that it will be.

PRO PROGRAM SHOULD BE REVIEWED

We think that the Congress should review the PRO Program. It certainly has cut down on admissions, and it's reduced the cost ot the Medicare Program.

But there are some things that need to be addressed. One of those is the paperwork that's required. Our studies show that there is a cost of $15 to $55 per admission just to furnish the paperwork to the PRO. Based on annual cost, that ranges between $1.5 and $4.2 million which is not covered by the Medicare Program and has to be charged to other patients.

Congress should not relinquish its effort to have Medicare payments adjusted for those hospitals which serve a disproportionately large number of low income and Medicare patients because such payment adjustment will help preserve access to high quality care for these individuals. Congress has been concerned about this, and the ability for Congress to address this. Efforts have been made by the administration not to make an adjustment here, but we urge you as a Member of Congress to push for that change and to support that legislation.

Congress should enact legislation that would require prospective application and periodic updates of Medicare's area wage index under the new DRG reimbursement system. Present law requires

that it be made retroactive. If that is made retroactive, and which was an error in the Nashville area of the government, not of the hospital, then hospitals would have to pay back some several million dollars, and yet in other areas of the State they would gain several million, We are supporting legislation that will make that prospective, not retrospective, and we hope that you support that.

In closing, we would urge you to continue to support tax exempt bonds for nonprofit hospitals. The elimination of this will——

Senator SASSER. They are eliminated under the President's tax reform proposal, as I recall.

Mr. LANE. Yes, sir, this is true, but it's a very important part of our ability to continue to take care of the poor and the elderly, because if we lose that ability we won't be able to have the facilities to take care of any of them. So we urge you to consider that program.

We appreciate the opportunity of sharing this information with you. We are concerned about the cost of health care. We are working on it around the clock. Costs have been cut drastically in the last 2 years. We continue to operate programs like group purchasing and the sharing of services, the sharing of equipment to lower the costs, but we want to work with you and your staff in any way that we can to work for corrective legislation that will make this a better program to serve the elderly and the poor of our State.

Thank you, sir.

Senator SASSER. Well, thank you very much, Ira, for your testimony here today, and we'll have some questions for you in just a moment after we hear from Mr. Stone.

[The prepared statement of Mr. Lane follows:]

STATEMENT

TENNESSEE HOSPITAL ASSOCIATION

UNITED STATES SENATE BUDGET COMMITTEE

AUGUST 30, 1985

NASHVILLE, TENNESSEE

Senator Sasser, on behalf of the hospitals of Tennessee, we welcome this opportunity to discuss the long-term viability of the Medicare trust fund and to provide testimony regarding the cost of health care, especially for the poor and elderly of our state and nation.

I am Ira M. Lane, Jr., president of the Tennessee Hospital Association. Our membership is made up of all types of hospitals and we represent the vast majority of all hospitals in Tennessee.

Tremendous changes are sweeping the health care industry at both the state and national levels. We are in a period of rapid transition that is reshaping not only the way health care is delivered, but also how health care is financed in both the private and public sectors. We are experiencing a revolution in health care unparalleled since the adoption of the Medicare and Medicaid programs under the administration of President Lyndon Johnson.

President Johnson believed, and Congress agreed, that health care is a basic right of every American citizen and the Medicare

and Medicaid programs were adopted to assure that right for the poor and elderly. In introducing these programs to the American public, President Johnson said, and I quote, **"The Great Society asks not how much but how good."**

Today, 20 years later, our nation is spending $1-billion a day for health care and some predict the eventual collapse of the Medicare system if reform measures are not taken to stem the increasing cost of health care. Two decades after the introduction of the Great Society programs, **we no longer are asking how much good can we do, but how much good can we afford to do.**

We have the technology. We have the physicians, nurses and other specialized personnel to deliver health care services that were only dreams a few short years--and in some cases, a few short months ago. But how many liver, kidney and heart transplants can we afford to do? Have we reached the point where our ability to provide health care has outstripped our ability to afford that care? Have we reached the point where we must ration these services? Some contend that we have already reached that point and that rationing has already begun. It is an ethical and moral dilemma for all of us working together to resolve.

However, we have very good news. The inflationary spiral of the 1970s and early 1980s has been broken and encouraging cost containment results have been achieved in both the private and public sectors. The hospital system is no longer expanding and may be actually shrinking.

Although significant problems remain, the Medicare system is no longer on the critical list. The condition of the system is much improved and the earlier prognosis that the Medicare trust fund would become bankrupt in 1985 has been changed. It now appears that the system will remain solvent for the remainder of this decade and perhaps into the next century. Social Security that once borrowed money from the Medicare trust fund is now able to lend money should an emergency arise with short-term Medicare funding.

This improved condition report was brought about by hospital cost containment programs and by the adoption of the new diagnosis related group prospective payment system for hospital reimbursements under the Medicare program. Hospitals supported the change away from the cost-based retrospective reimbursement system to the new prospective pricing system. This new system promised to provide predictable payments, as well as positive incentives for hospitals to be more efficient and more productive providers. Initial results of the DRG system are very encouraging:

- **TOTAL HOSPITAL EXPENDITURES ARE NO LONGER ADVANCING AT THE DOUBLE-DIGIT RATES COMMON DURING THE SUPER-INFLATIONARY PERIOD OF THE 1970s.**

Between 1975 and 1982, annual hospital expenditures advanced on an annual average of 16.2 percent. That rate had dropped to 10.2 percent by the end of 1983 and to only 4.6 percent after the implementation of prospective pricing in 1984. This slowdown in expense growth came about despite an increase in the cost of goods

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and services purchased by hospitals. Two factors seem to be most responsible for this decline--fewer hospital admissions for inpatient care and efforts by hospitals to hold down the cost per case.

- **TOTAL ADMISSIONS, WHICH STARTED TO DECLINE IN 1983, FELL SHARPLY IN 1984. A 4 PERCENT DECLINE IN 1984 ADMISSIONS WAS LARGELY DRIVEN BY A DECLINE IN ADMISSIONS OF PATIENTS UNDER AGE 65, BUT ADMISSIONS OF PATIENTS AGE 65 AND OLDER ALSO DECLINED.**

Under age 65 admissions fell 4.5 percent in 1984. A gradual decline in admissions of patients over age 65 started in the third quarter of 1983, but 1984 was the first time that admissions for this age group declined for a full calendar year. Admissions of patients age 65 and over increased 4.7 percent in 1983 but declined 2.9 percent in 1984.

A survey of our members indicates that Tennessee hospital occupancy rates have declined during the last 2 years, falling from an average of 68.77 percent in the period October 1983 to March 1984 to 62.77 percent during the period of April to September 1984.

Changes in private health benefit plans, advances in technology which allow for more outpatient treatment, and changes in medical practice patterns are the three major factors which added impetus to declines in hospital admissions of private patients.

The Medicare prospective payment system did not become fully implemented until the third quarter of 1984, but the system, along with private sector initiatives, has encouraged hospitals to more effectively manage cost per admission. In addition to declining

admissions, hospitals have responded to the new incentives by reducing the average length of stay, reducing personnel and reducing the number of staffed beds.

- **Length of stay nationally had been reduced by 5.1 percent at the close of 1984 to only 6.5 days. Similarly, in Tennessee, the average length of stay for all patients fell from 6.4 days in the fourth quarter of 1982 to 5.77 days at the close of the third quarter of 1984, according to our survey of member hospitals. In Tennessee, the average length of stay for Medicare patients dropped from 8.33 days in 1982 to 7.02 days in 1984, a 12.47 percent decline from the previous year.**

- **Full-time equivalent personnel employed by hospitals nationally had dropped by 2.3 percent at the close of 1984. In the first quarter of 1985, hospitals nationally continued to respond to cost containment incentives and lower utilization by reducing staff. A 0.5 percent decrease brought FTEs down to 3.05 million, the lowest level since the second quarter of 1981. Since peaking in the second quarter of 1983, FTEs have dropped by 145,000 nationally.**

Last year was the first time in 22 years that full-time equivalent personnel and staffed hospital beds declined for a full calendar year. Although part-time positions were cut, deeper cuts were made in full-time positions. We estimate that in excess of 2,500 hospital positions have been eliminated in Tennessee during the last 2 years as a result of early retirement plans, hiring freezes and layoffs in many communities across the state.

- **The number of staffed beds nationally had been cut by 1.1 percent at the close of 1984. In addition to reducing staff, hospitals continued to respond to incentives and demand pressures by cutting beds in the first quarter of 1985. A 0.6 percent reduction left the staffed bed level nationally at 977,000, down 29,000 from the peak level of 7 quarters earlier.**

The decline in average length of stay is consistent with the new incentives of Medicare prospective pricing and private sector health benefit changes. Declines in average length of stay during 1984 were especially sharp for Medicare patients.

Hospital efforts to hold down overall costs also can slow cost per admission. The increase in cost per admission rose only 7.5 percent in 1984, compared to 10.2 percent in 1983 and an average of 14 percent during the period 1975 through 1982.

In addition to contributing to slower growth in cost per admission and total expenses, hospital cost containment efforts enabled the industry nationally to experience slight gains in both operating and patient care margins. It is important for hospitals to maintain positive margins in order to generate and access needed capital and to better prepare to cope with the risks inherent in a prospective pricing environment.

It is expected that the hospital operating environment in 1985 will be characterized by slightly reduced inflation and continued emphasis on cost containment in both the public and private sectors. Medicare has already introduced a new change. HMOs and competitive medical plans can now contract with Medicare to enroll Medicare beneficiaries.

The Medicare Peer Review Program, introduced in 1984, will increase downward pressure on hospital utilization in 1985. Additionally, changes in private sector benefit plans and advances in outpatient and home care that have already occurred all point to a continuing decline in demand for inpatient hospital care and an increasing demand for non-inpatient and non-acute care services.

All of these indicators are good news to those interested in hospital cost containment. They show that hospitals are

responding to public demand and the discipline of the marketplace.

However, the early promise that Medicare prospective pricing would assure predictability through fair and equitable payments has not been realized. The Medicare system has undergone major and not-so-delicate budget surgery. Direct payments by beneficiaries have increased and payments to hospitals have been whittled away.

The 1986 Budget Reconciliation Act includes an $11-billion reduction for Medicare over the next 3 years and hospital payment levels have been frozen at 1985 rates. This so-called freeze adds up to an actual reduction in Medicare spending for hospital services in the amount of $435-million. These reductions are heaped upon previous reductions that have equated to $27.4-billion over the past 4 years from projected levels. Furthermore, beginning with the Omnibus Reconciliation Budget Act of 1981, Medicaid payments have been reduced rspectively for the years 1981, 1983, and 1984 by 3 percent, 4 percent, and 4.5 percent. The proposed budget for Medicaid calls for an added $1-billion reduction for fiscal 1986. This is a particularly disturbing trend in light of the growing problem of medical indigency in our state and the nation as a whole.

Unless we are careful, we may ultimately cut too deeply into the fabric of the social safety net for many older citizens and poor people. More than 330,000 Tennesseans--mostly women, children and retired persons--have no health insurance and are not covered by state or federal programs. Hospitals traditionally

have taken care of these unmet needs through direct charity and by absorbing bad debts. Last year, Tennessee hospitals provided approximately $300-million in such care. Add to that another $400-million because of under-reimbursements from state and federal programs and the total amount of uncompensated care in Tennessee is approaching three quarters of a billion dollars annually.

Under-reimbursements from Medicare have been particularly dramatic. Data from 1982 shows that Medicare patients in Tennessee paid directly only 6.4 percent of hospital charges; Medicare reimbursed 57 percent of charges, leaving 36.6 percent to be absorbed or subsidized by the hospital through higher charges to private patients.

The ability of hospitals to sustain high levels of uncompensated care is being rapidly eroded because of low profitability in many services and by increasing demands for discounted services from Health Maintenance and Preferred Provider Organizations. Additional competition is coming from new providers entering the marketplace thus placing additional pressure on hospitals to hold the line on costs and prices.

It is possible for hospitals to make a profit under the Medicare prospective payment system, but when profits do occur the margin is generally small. Although the national economic picture for hospitals is good following implementation of prospective payments, the picture is not so bright for some types of hospitals. Many of those hospitals are not profitable and will have difficulty surviving under the DRG system.

These hospitals are frequently small, located in rural or inner city areas, are owned by local governments or nonprofit organizations and serve large numbers of low-income and elderly patients. Many are affiliated with medical schools and local colleges and provide expensive educational and research programs.

Federal reimbursements under the Medicare and Medicaid programs must be flexible enough to preserve the diversity of hospitals which are meeting the needs of different communities across Tennessee and the nation. The diversity of our hospitals is the strength of our health care system. Hospitals cannot be painted with the same brush. They need individual considerations.

Clearly, hospitals have entered a new era. And as predicted, there will be winners and there will be losers as hospitals take a more businesslike approach to providing health care in a competitive market. Some hospitals will surely close but many others will survive by closing unprofitable services, by controlling the amount of uncompensated care and by adopting marketing strategies to provide alternatives to inpatient hospitalization.

In this arena, the question arises, "Who Pays for the Poor?" It is a question that strikes at the heart of our social consciousness. It is the Achilles' heel of the new health care marketplace. It also is the question no one likes to ask because no one likes the answer. The answer, of course, is that we all pay, one way or another. The real question is "How are we going to pay?"

It is the position of the Tennessee Hospital Association that uncompensated care is the responsibility of society as a whole and should be financed through broadly based taxes at the state and federal levels.

The federal government has a special responsibility both to the poor and the elderly, many of whom are also poor. Already, however, budget cuts and payment freezes have affected both Medicare and Medicaid. Continued budget cuts may make political winners, but our poor and elderly will be the losers.

Fairness and equity must be maintained under the Medicare prospective payment system.

To accomplish this goal, there are several specific areas to which Congress and HCFA should address themselves:

- **Congress should enact legislation to allow DRG rates to be adjusted to take into account patient conditions. Significant hospital payment inequities exist when Medicare DRGs are not adjusted to account for severity-of-illness factors. Both teaching hospitals and public hospitals frequently treat sicker, more costly patients than some other hospitals, but the DRG system does not take this into account for payment purposes. Teaching hospitals often serve as tertiary referral centers for difficult cases, and public hospitals treat poor patients whose illnessees may be advanced or involve complicating factors.**

In a study published in the July 4th issue of the New England Journal of Medicine, researchers found that switching to severity-adjusted DRGs would have little effect on some hospitals but in others could result in payment differences as great as 35 percent of a hospital's total operating costs.

The issue of severity indicators and whether some hospitals systematically treat sicker and more costly patients is in the short run an issue of fairness and equity. Even if the DRG system

does not fairly match payments with treatment costs, the DRG per case payment method creates incentives for hospitals to cut costs. However, researchers say, payment inequities could affect access to hospital care by creating "perverse incentives to transfer or avoid some kinds of patients while selectively recruiting others...Furthermore, hospitals which continue to treat all patients in the face of these irrational incentives could face severe financial problems." In the long term, this could make the health care system less efficient.

Congress should encourage HCFA to research case-mix classification to determine whether the DRG system is fair to classes of beneficiaries, to individual facilities and to classes of hospitals. If it is not fair, it is important to correct it. If it is fair, it is important to show that it is fair because "erroneous beliefs that the system is unfair may create access barriers for some Medicare beneficiaries", such as the poor, the frail elderly and the disabled.

DRGs do not adequately take into consideration complicated cases involving more than one diagnosis. For instance, a patient admitted with a primary diagnosis of diabetes may be subsequently found also to be suffering from hypertension and heart disease. These conditions complicate the case and require more resources for adequate treatment. Although prospective pricing attempts to deal with these complicated cases as outliers, there appears to be confusion between Professional Review Organizations and hospitals about how to handle these cases. This confusion frequently leads to a denial by PROs of adequate payments. This may produce an

incentive to discharge patients after treatment for the primary diagnosis and then to readmit the patient at some later time under another DRG.

Some observers fear that Medicare patients may be discharged prematurely, but there is as yet no convincing evidence of such a trend, although there have been some isolated incidents of inappropriate discharge.

Professional review organizations are charged with the responsibility to review the appropriateness of admissions and quality of care, as well as the necessity for readmission and the appropriateness of discharges. In this connection, we believe that PROs need to more closely evaluate complicated cases and help to better define the DRGS to handle them so that hospitals will receive adequate payments for care rendered.

- **Congress should examine the PRO review process to reduce costs. The PRO review process also is designed to assure that patients receive only the care that is necessary and that care is delivered in the most economical setting. However, this review process is imposing a substantial burden of paperwork on hospitals.**

A membership task force of the Tennessee Hospital Association has studied the cost of providing medical records and patient charts to the PRO for review. The study indicates that the direct cost of complying with PRO paperwork requirements ranges from $15 to $35 for each review. This includes the cost of photocopying and shipping records but does not include substantial labor costs. With an estimated 100 to 125-thousand reviews each year, it is costing Tennessee hospitals between $1.5 and $4.2-million annually to provide records to the PRO. Not only is this a considerably

higher cost than we were led to expect, the cost is not reimbursed by Medicare.

We believe that paperwork requirements should be looked at in light of the Federal Paperwork Act which is designed to reduce unneccessary and costly paperwork requirements. In addition, we believe that reviews done onsite are a better alternative to reviews at a distant office where reviewers do not have access to personnel who can answer their questions.

- **Congress should not relinquish its efforts to have Medicare payments adjusted for those hospitals which serve a disproportionately large number of low-income and Medicare patients because such payment adjustment will help preserve access to high quality care for these individuals.**

Despite Congressional directives, court orders and recommendations by the Prospective Payment Assessment Commission (ProPAC) since 1983, HHS delayed implementing the adjustment until just a few weeks ago. However, the Health Care Financing Administration (HCFA) is appealing the court-ordered deadline and has said that it will retroactively void the regulations if it wins a court appeal.

Congress has been concerned that DRG payments do not adequately reimburse disproportionate share hospitals for higher costs associated with treating low-income and Medicare patients. Likewise, ProPAC feels that if "these higher costs are not adequately taken into account, the quality of care provided to Medicare beneficiaries in these institutions may deteriorate over time. Access to services also may be seriously compromised as a result of inadequate payment policy."

A preliminary Congressional Budget Office (CBO) report found that under a fully implemented DRG system, disproportionate share hospitals would fare worse than other hospitals. This would be particularly true for large not-for-profit hospitals in urban areas. Overall, disproportionate share hospitals would receive 3 percent less than under prior law, but urban hospital would receive about 4 percent less than previously. "On average," CBO reported, "for each 10 percentage points that the ratio of Medicaid inpatient days to total patient days increases, a hospital's deficit would increase by 2.5 percent."

The American Hospital Association has noted that many of these hospitals operate with older physical plants and equipment, have higher security and parking facility costs, often acquire "leading-edge" medical technology or offer unprofitable but expensive and necessary services such as burn units, and suffer disadvantages in payments because they are located in areas covered by flawed area wage indexes.

- **Congress and the Health Care Financing Administration should allow hospitals the flexibility to convert excess bed capacity to subacute care in order to provide services to Medicare patients who may be discharged at an earlier state in their recovery because of incentives provided under the prospective payment system.**

The prospective payment system and professional review organizations are both encouraging hospitals to utilize appropriate levels of care in the treatment of Medicare patients. This has led to shorter hospital stays and actual reductions in hospital admissions. This, in turn, has led to an increasing need for subacute care as patients are discharged earlier, or as alternatives to acute care are sought.

While the DRG payment system encourages hospitals to discharge patients at an earlier state of recovery, it may be difficult for hospitals in some areas of the country, such as Tennessee, to place those patients at appropriate levels of care following hospital discharge. Many existing nursing homes are full with national occupancy rates of 90 percent. Those with vacancies are reluctant to accept Medicare patients discharged early from hospitals. These patients tend to be sicker and require more intensive services than the average nursing home patient. For nursing homes to accept these patients, they would need to increase staffing ratios and upgrade both services and equipment at considerable cost.

Hospitals should have the flexibility to meet the changing needs and demands of their patients and communities. We support the extension of the "swing-bed" program to allow more hospitals to use under-utilized acute care beds to serve subacute care needs.

The Omnibus Reconciliation Act of 1980 included a provision allowing hospitals with 50 beds or less to utilize acute-care hospital beds for skilled nursing care. However, because of the arbitrary 50-bed limit, many hospitals are prevented from participation. This creates serious problems when there are significant shortages of skilled nursing care beds and patients often must travel great distances away from their families to get the care they need. Moreover, a lack of skilled nursing care beds places an excessive financial burden upon hospitals which must

keep patients in the acute care setting when the alternative of skilled nursing care would be more appropriate and less costly.

Under the old payment system, patients who were backed up in hospitals waiting for long-term care were not a financial concern for hospitals since Medicare paid for "administratively necessary days." Under prospective payment, however, hospitals receive a marginal per diem for "outliers," cases that are high cost or exceed a DRG's length of stay threshold. The hospital must absorb the total cost if length of stay exceeds the DRG average but falls below the outlier threshold. In addition to providing incentives to discharge patients earlier than in the past, the system creates incentives to transfer those patients who are potential "back up problems" early in their stays.

- **Congress should enact legislation that would require a prospective application and periodic updates of Medicare's area wage index under the new DRG reimbursement system.**

A serious flaw in the application of area wage indexes under prospective payments was identified during the first six months after the new reimbursement system was implemented. Eventually, these flaws were eliminated through congressional action. Current law mandates retrospective implementation of the index to October 1, 1983. However, retroactive application of the new index would cause dislocation and hardships for many hospitals and flaws in the current index also would imperil rural hospitals.

Legislation to allow prospective application of the new index and periodic updates has been introduced in both the House and Senate. Senate bill 1478 was introduced in July by Senators James Exon of Nebraska, Charles Grassley of Iowa and William Proxmire of

Wisconsin. Similar legislation, H. R. 2819, has been introduced in the house by Representative Hal Daub of Nebraska.

- **Congress should preserve tax-exempt bonds for use by private not-for-profit hospitals because elimination of this method of financing could jeopardize the long range survival of many local hospitals and would add considerable cost for both private and government-sponsored patients.**

Access to capital is a critical issue for hospitals. The ability of hospitals to continue to provide high quality medical care depends heavily upon success at capital formation. Capital projects are primarily undertaken for modernization and restructuring of outstanding debt, keeping facilities in compliance with life and safety codes and financing the purchase of sophisticated medical equipment.

Should tax-exempt bonds be eliminated, not-for-profit hospitals will be forced to compete for capital in highly competitive commercial markets where interest rates are higher. This increased cost ultimately would be passed along to patients and the government itself.

These hospitals would frequently be at a competitive disadvantage in capital acquisition. Elimination of tax-exempt bonds would threaten the long-term viability of some hospitals since many not-for-profit hospitals do not generate large enough margins to qualify for commercial capital. Those which do qualify often find that instead of having a 30 year payback period, commercial lenders require paybacks in 10 to 15 years.

Failure to preserve tax-exempt financing would have a devastating impact on nongovernmental, nonprofit hospitals. These

institutions, which comprise 58 percent of the nation's community hospitals, have been historically rooted in the not-for-profit sector and viewed as charitable organizations fulfilling an indispensable community service, especially by providing service to the poor and economically disadvantaged. It is our position that it would be shortsighted to make further fundamental changes in the hospital financial system given the dramatic changes occurring in the hospital field as a result of the Medicare prospective pricing system and increasing competition.

Senator Sasser, we appreciate your interest in the health of our hospital system because the health of our hospitals is tied directly to the health of our citizens. We want to continue close contact with you and your staff so that we may assist you in meeting the challenges that confront us today and are ahead of us in the future. We offer you our assistance and pledge our support of efforts to maintain high quality health care services accessible to all at reasonable costs. Thank you again for allowing us to participate in today's hearing.

Senator SASSER. Mr. Stone, if you do not have a prepared statement, perhaps you'd like to make some observations here.

STATEMENT OF JOHN STONE, DIRECTOR, HOSPITALS FOR METROPOLITAN GOVERNMENT IN NASHVILLE AND CHIEF EXECUTIVE OFFICER, GENERAL AND BORDEAUX HOSPITALS

Mr. STONE. Thank you, Senator Sasser. Let me thank you for allowing me to participate in the hearing today. Let me, if I may, share with you some information that relates to information regarding Davidson County. As you know, Mr. Lane just shared with you some figures as related to charges for services of patients not reimbursed to hospitals by either the State of Federal Government, and also those through bad debt and charity care, and he present a figure of $721 million for fiscal year 1983-84. In Davidson County that totaled $721 million. There was $106 million not covered in Davidson County. The contractual allowances, that's what is not covered under Medicare and Medicaid, that total is $52 million, and charity and bad debt is $54 million.

LOCAL TAXPAYERS GIVE SUPPORT

We are fortunate in this county, and several other urban counties that are in Tennessee, to have some support from the local government through local taxpayers. As you know, Metropolitan Nashville, Davidson County operates two facilities, Metropolitan Nashville General Hospital, which is a short-term acute care hospital, and Metropolitan Nashville Bordeaux Hospital, which is a long-term or chronic convalescent facility which currently has 175 on the waiting list to get into that facility.

This past year, talking about actually 1983-84 figures, General Hospital, in the charity and bad debt write-off, which was actually partially covered through the local taxpayer, we had $18,795,000 that was provided for charity and bad debt. That figure, when compared to the percentage of our budget, was right at 60 percent. I'm sure you can imagine that if we had the health care delivery system that some of our other counties may have, you can imagine the burden that would be shifted on those other hospitals. So we are indeed fortunate to have.

But we are also faced with a major crunch. You heard there have been decreases in the admissions. This has not happened in the public hospital. Ours continue at a steady rate, and, it's ironic, has increased just recently. We also found an increase in referrals. Some people use it as dumping. But we find increase of referrals of those patients that are not able to pay for their health care, and part of it is because they are not adequately insured, they do not have adequate coverage, or possibly because that facility may not be providing that type of service.

Again, we support your efforts to keep the Medicare fund viable, and will work with you and your staff in providing you with any information that you may need to help support the position of the citizens of Tennessee.

Senator SASSER. Well, thank you very much, Mr. Stone.

QUALITY OF HEALTH CARE NOT AFFECTED

Mr. Lane, what impact do Medicare reimbursement cuts have on the hospital's ability to provide quality health care? What have you seen with regard to health care in the last couple of years as we've seen Medicare cuts coming down the pike?

Mr. LANE. Senator, I don't think the quality of care has been affected as yet. Previously we delivered three types of care, medical care, social care and convenience care in our American society. With the cutbacks the social aspects of that care as been eliminated, and we simply mean here for an elderly person who's admitted to the hospital, a doctor could discharge on Wednesday, they had no one at home to take care of them, they had to arrange a son-in-law to get off from work to go do that, that part has been eliminated through these cuts.

Senator SASSER. Could you pull that mike a little closer? They may be having a little difficulty hearing you in back.

Mr. LANE. The convenience part of the care in our society, we have had a tendency that we had to go in the hospital for everything, and it's convenient to go in, lay in a bed and have a nurse wait on you. We have seen in the last 2 years with cutbacks, and with also the cutback in the private sector, that care has moved to the outpatient basis. For instance, you get operated on, you go home, your wife changes the dressings rather than the nurse changing it in the hospital. We've seen that.

So far we have not seen a cut in quality, and we hope that we will not.

I think what we are facing, and what we fear and is our greatest fear, because of the cutbacks, the hospital's ability to continue to take care of just the pure charity and indigent patient is greatly being reduced. In other words, we are barely able to survive with what we get from the Medicare/Medicaid Program. As the PRO's are formed and the industry begins to pay a much lower share for its cost, we are going to see the ability of the hospital to continue carrying a $300 million load greatly reduced. So I think we need to look at that and find out what we can do to continue offering care to all of society, and not just to a segment of society.

MIDDLE CLASS SQUEEZED OUT

Senator SASSER. Well, that brings up another question here. I have heard testimony this week, particularly in Memphis, which indicates that there's a trend in the health care system under current policies to a so-called two-tier health care program, one for the haves and a second for the have-nots. There was also testimony which suggested we may be going toward a three-tier health care system, one for the haves, one for the have-nots, and one for those who are simply squeezed out, and they get very little health care. And the position was taken that a large percentage of the middle class, as they age, may enter into this third tier of so-called squeezed-out individuals. Do you see a two-tier or a three-tier health care system developing, and is one of those tiers moving in the direction of inadequate medical care for our people?

Mr. LANE. Senator, I think we very definitely throughout the country, not just Tennessee, are moving to a two-tier system. We

did a study, and 43 percent of our services were provided to the Medicare/Medicaid patient, 3 percent to the charity patient, 4 percent was bad debt, and 3 percent was medically indigent. That simply said that 47 percent of our patients were pay patients and paid not only their bill but a markup. These people who are employed, who are making a good income, who have a good insurance policy, are going to continue to demand the best. They are not going to settle for bargain basement. And so consequently, in order to continue offering care to people, you are not going to be able to put that level of care on that paying patient for the simple reason that he's not going to accept it. He'll go somewhere else and get it if you don't provide it. But in order to continue to provide care, I don't mean less than quality care, but I'm talking about a lot of the convenience that goes along with medical care, to that extent there will be two-tier.

ACCESSIBILITY TO CARE IS THREATENED

Our fear is not with two-tier care. Our fear is the ability to take care of people period. A hospital can only pay out the amount of money it can take in, and if the money isn't there, it will not be able to take the hundreds of charity patients it now takes. Hopefully we'll find ways to do that in an outpatient department at a greatly reduced cost, and that in itself would be a form of tier, a level of care other than inpatient. But if you don't have the money, and we are hearing from our county government and State government and Federal Government that they are going to have to cut back, they can't afford it, we are hearing from industry we are no longer going to pay the markup to pay for other people. Now when all of that comes together, the dollars won't be there to continue providing the same amount and perhaps the same level of care. We are going to provide quality care as long as we possibly can, but the numbers of care, the accessibility to care is really being threatened for the thousands of poor people across the country. And some answer needs to be found, and we as an association have just employed two consulting firms to study with government how we are going to find an answer to this. So we are concerned and we want to do something about it.

Mr. STONE. If I may respond just for a moment just to put it on a more local basis. Had the metropolitan government through the mayor's court and the metro council court not given our increase, we would had to have cut back services, maybe even eliminate some perhaps at Metropolitan General Hospital. We serve as a hospital of last resort. If there are continued cuts in Medicare and if there are any further cuts in Medicaid or erosion of Medicare, we find ourselves strapped with not being able to pick up on the local basis.

We are watching the Federal revenue sharing right now. We have $1 million that comes through General Hospital. If that is lost in the next 2 or 3 years, then in turn we are talking about approximatrely 5 percent of our budget. And that equates to patient care. So we are very concerned about any cost shifting that may take place at any level.

Senator SASSER. Well, you may be aware that revenue sharing has been zeroed out in the fiscal year 1987 budget, so you may get an additional financial shock beginning in the fall of 1986.

INDIGENT PATIENT BEING SHIFTED

Mr. Stone, do you see the current Medicare policies as creating an incentive for private hospitals to transfer patients to public hospitals? You referred a moment ago to perhaps dumping, and I realize the private hospitals are under great cost pressures. Are these Medicare policies providing incentives to the private hospitals to move these Medicare patients out, to get them off their hands, because they are not being adequately compensated, and to push them over into public hospitals?

Mr. STONE. We are not seeing the shift in the Medicare patient. We are seeing the shift in the medically indigent patient.

Senator SASSER. In the indigent patient?

Mr. STONE. Those patients that do not have the resource to, say, take care of their medical care. I had a patient in my office yesterday from a neighboring county that had incurred a major bill at a local hospital in her county a year ago, was to go back there for further care, and was unable to get in because she did not have adequate finances to cover for her care. She presented herself at three hospitals here and ended up at General Hospital.

We are working with the State to see what we can arrange back in that county through that health department, but again we are seeing the shift in the medically indigent to the public hospitals, and it's increasing.

Senator SASSER. Well, gentlemen, you are both experts and careerists in the field of hospital administration and health care, and you've seen many years of it, and you've had a lot of hands-on experience with it, and there's a lot of uncertainty as to what health care will look like in the future, what the configuration of health care will be, whether or not we as a nation can even afford to deliver quality health care to a population that is continuing to age. And we are grateful that people are living longer, and I think that is primarily a result of better health care and partly a result of better nutrition.

But if you would look into your crystal ball, Mr. Lane and Mr. Stone, what do you think our health care system might look like 10 years from now? If I came back here in August of 1995, what might our health care system look like here in Nashville, TN?

PAYING FOR INDIGENT CARE WILL BE ACCEPTED PRACTICE

Mr. LANE. I think that we will continue to have one of the finest health care systems in the World here in this country. I think much of the convenience of health care is going to be cut out when we go strickly to providing straight medical benefits, in many cases on an outpatient basis rather than an inpatient. I think that you'll see more—faster service, perhaps, where you go in and not have to wait as you do in some places now. I think there will be a public consciousness develop of the need to finance indigent care. I think we will find a way to do that, and hopefully that solution is around

the corner, where everyone in society feels a responsibility and participates through some general taxation to pay for indigent care.

For many years we provided millions of dollars in indigent care, and the sick patient, the one who went to the hospital, one out of six paid a markup to pay for the indigent patient that didn't pay. It would be so much better to have all people, all sick people in society, pay for that, rather than when he's unable to pay his own bill, and then he's taxed with somebody else's bill. I think the public is waking up to this. And I believe that we will see a method to finance this like we've found methods to finance education and prisons and other programs. I believe that we will continue quality care, we will continue to develop technology that did fantastic things, but I believe we will find how to provide care at lower cost. Competition is going to help do this; I think a public consciousness that it's safe to go and have an operation on an outpatient basis. We are going to find out how to do that. But I think most importantly, we as a society are going to find a way to pay for indigent care, and I believe that 10 years from now that will be an accepted practice.

Senator SASSER. Do you want to add to that, Mr. Stone?

Mr. STONE. Let me just add a comment or two. I think if you are looking at 1995, I think you will find your acute care hospitals will be intensive care hospitals. I think you will find that the majority of health care will be delivered on an ambulatory or an outpatient basis. Now if technology is not thwarted and it continues to receive adequate finances, I think we may not be able to imagine really what it will be 10 years from now because of the advances that have taken place, as yesterday the heart transplants, as you look down the road. But again, I think by then we will probably have developed a national health policy, either through working through States going to the national level, as relates to health care and health care delivery.

TRADEOFF LIKELY

Senator SASSER. Gentlemen, let me ask you this. I'll address this to you, Mr. Stone. What about tradeoffs between costs, hospital costs, health care costs, tradeoff of quality a tradeoff of access to health care? Can we have all of these at the same time—a reasonable cost, quality health care and general access to health care—in your judgment?

Mr. STONE. Not in the present system, and I think as we are looking down the road, I think there will be a tradeoff. You may can have two out of the three, as we are currently living in the system.

Senator SASSER. Sure.

Mr. STONE. And, again, it's not to give you a health care economics course, but just as we look at the issues, as we are looking at health care delivery and the health care system, I think we all would like to have quality health care, I think that's what we ought to expect. I think we all would like to have accessible and available—not immediately available, but available—health care. I think we all want lower consumer cost and lower hospital charges, and I can assure you that as a hospital administrator we are con-

stantly looking for ways to lower our hospital cost and charges, because we live on a budget. The budget provided to us by the local metropolitan government, through the metropolitan government, through the taxpayers, that's all we have to live on, and we must stay within that budget. But as you look at it, you really can't have all three. You can have two of the three in the present configuration, but you can't have all three. Once we reach a point that we get to the lowest hospital charge from the standpoint of——

Senator SASSER. John, why don't you put that chart over there. There are some people in the audience that might want to see this.

Mr. STONE. As hospitals are looking to reduce its cost, it will reach a point where it cannot reduce it any further without impacting quality or the accessibility. Right now we are seeing the accessibility that is being impacted. Hospitals are looking for ways to reduce their cost.

ACCESSIBILITY IS LIMITED

Senator SASSER. So as they are trying to shrink their cost, what they are doing is limiting accessibility?

Mr. STONE. Accessibility would be impacted.

Senator SASSER. Right. And we've heard testimony today by the legal services attorney, which indicates that there are people in the population who simply cannot afford the hospital care. We heard testimony from Mrs. Leech who indicated that the Medicare DRG setup was not allowing her to go into the hospital for this last procedure which she wished to do, and which her physician recommended. So that is a limitation of accessibility.

Mr. STONE. Right.

Senator SASSER. Go ahead.

Mr. STONE. You could have quality health care, and let's say we all want that, and you can be accessible to all.

Senator SASSER. Right.

Mr. STONE. But you cannot put this construction that we are going to cut back on what we are paying for the health care. You can have accessible health care and lower cost, but you may impact then the quality. Ten dollars to take care of those patients may not be able to do it as quickly, or in the same manner. You could have accessible. I think probably accessible and lower, and that would impact then the quality. So there are combinations. But, again, you can have two of the three in the current configuration, until everyone agrees that they ought to absorb their share of the responsibility. Thank you.

Senator SASSER. Thank you very much.

Ira Lane and John Stone, I want to thank you very much for appearing here today and giving us the benefit of your views. They've been very very helpful. Ira, I look forward to reading your books when you get them published on the problem of health care.

Do you wish to add something else?

Mr. LANE. Senator, let me just give you the following illustration. If you take 120 admissions of a Medicare patient to two hospitals as just a sample to show the amount paid by the patient and the amount paid by government. And another point to call to your attention, 15 percent of those patients couldn't pay the deposit. So

consequently they were treated, the deposit wasn't paid, but somebody has to pay. And consequently that cost was cost-shifted to someone else. I'm sure there are patients who don't get in, but there are hundreds of them who do, because they can't afford the deposit.

INSURANCE COMPANIES ENTITLED TO RELIEF

Senator SASSER. But you were indicating earlier that you are now having to deal with health insurance companies and large employers who are coming around to see you now wanting their charges reduced. In other words, is there now a general awareness that there is a so-called sick tax, as you described earlier, and many of the insurance companies, the employers, in an effort to see lower health care costs for themselves are trying to drive a harder bargain and along the way escape paying the sick tax to a certain extent?

Mr. LANE. Senator, for many years industry carried the load of paying for indigent care because of the cost shift, and, of course, the insurance companies wrote coverages for those industries. They are entitled to relief. Our point in making the comment that we did, as they get relief, it leaves a void, and unless something in society fills that void, accessibility to care is going to be greatly affected.

Senator SASSER. Gentlemen, thank you very much.

Mr. STONE. Thank you.

Senator SASSER. Our last panel of witnesses includes a private physician and a representative of the home health care industry.

Dr. John Wright is currently the chairman of the board of directors of the Nashville Academy of Medicine, and is president-elect of the Tennessee State Chapter of the American College of Surgeons. Dr. Wright belongs to numerous professional organizations including the American Medical Association and the Tennessee Medical Association. He received his medical degree from the University of Tennessee College of Medicine in Memphis in 1959, and received his bachelor's degree in medical science from Tennessee Technological University in 1957.

Dr. Wright will be joined by Mrs. Gayla Sasser who, I'm admonished to say, is no relation to me. I guess Mrs. Sasser will want to make that clear, I don't know. She is currently the executive director of the Tennessee Association for Home Health. Mrs. Sasser has served in numerous capacities in the home health care field including administrator of home health care and executive director of the Tennessee Health Facilities Commission. Dr. Wright, we'll begin with you, sir, and we are grateful to you today for appearing here, and doubly grateful to you for waiting so patiently to present us with your views.

Dr. WRIGHT. Thank you. Is this appropriate sound?

Senator SASSER. Yes.

STATEMENT OF DR. JOHN WRIGHT, CHAIRMAN OF THE BOARD, NASHVILLE ACADEMY OF MEDICINE

Dr. WRIGHT. Thank you, Senator Sasser, for the opportunity to appear before this committee. I do not have a prepared statement

but would like to address some of the issues that have been discussed here today.

Basically I think as a physician, and I think I echo the thoughts of most physicians, that the health care delivery system in this country is the finest anywhere in the world. I personally am not able to consider our station or status in health care delivery system in a so-called crisis environment. I think the information that has come forth in the past several months about the expenditures has been healthy and allowing us to allocate expenses for medical care delivery possibly more wisely.

To be somewhat historical, I think if we look back at the turn of the century when our people were self-sufficient and did not rely on the medical care providers as they do today, as time and technological advances have taken place we as a people have become more reliant upon a system to provide our health care for us. Beginning with the explosion of expenses in the mid-sixties, which we've alluded to on several charts, this particular time in our history was also simultaneously rewarded with technological advances that were unthought of and unheard of in the years prior to that time. All of these factors cause an increase in expenditure of health care, and in the learning process I suppose one could say our health care expenditures have gotten somewhat out of control.

Again, the arbitrary figure of expenditures of 10 to 11 percent of the gross national product is becoming excessive, but I personally don't know who made up that figure, but it is possible that the people of this country wish to spend more money for their health care than 10 or 11 percent of the gross national product. So these issues have not been resolved at this point.

REEDUCATE PEOPLE TO LIVE HEALTHIER LIVES

I think the expenditures for health care that we have today, if wisely allocated, I would—I would disagree somewhat with Mr. Stone who says that accessibility, affordability, and quality cannot be obtained with the expenditures at this present level, but I personally think those goals are obtainable. Our problems, as I see them as a physician, is reeducation of ourselves as people to live healthier lifestyles. We do not get sick if we take care of ourselves, we do not get sick as often. Sickness and illness knows no boundaries in terms of economic strata, but it has been well proven through the past several years that excesses and certain lifestyles lead to poor health; and when these lifestyles are altered we lead a healthier life. Likewise the expectations of patients have increased, possibly beyond obtaining, and this again is another reeducation process.

We may be turning in the next several years or decades to a more self-sufficient individual, more responsible for our health care, less smoking of cigarettes, less eating of fat foods, more exercise, more weight control, and I think we will see a result in less expenditures for heatlh care in the future.

In the present day environment, we currently are in 1985, and the physicians are in a fee freeze situation. I'm not sure that the physicians of this country appreciate that particular posture. It is a singular sort of an arrangement that I'm unfamiliar with in the

history of our country, and I think that this should be carefully reconsidered, lest it be considered at some point in the future as a punitive measure, which I don't think it should be.

Senator SASSER. I think to the physicians credit, Dr. Wright, if I'm not mistaken, they did undertake to freeze their fees voluntarily, did they not?

FREEZE ON FEES WILL HAVE DETRIMENTAL EFFECT

Dr. WRIGHT. They did that. Early in 1984, realizing that health care expenditures were possibly out of control, I think that the American Medical Association and all physicians were considered about this, and voluntarily the majority of physicians agreed to control their fees, hold their line on the freeze, and then three to four months later it was mandated that a fee freeze was in effect for the Medicare/Medicaid—Medicare individuals.

This in itself probably in the year that it's been in effect or 11 months has not had a detrimental effect on quality of care, accessibility, but at some point it obviously will. If all other factors being equal, and expenditures continue to rise, then it only makes economic sense that if my expenses go up, up, up and my fees are flat, at some point, I will either have to go out of business or subsidize my practice. And at that point, what point that occurs, I'm not sure. But it certainly will if it continues.

In the surgical fields, expenses to maintain a practice are roughly 25 percent, possibly; in the primary care fields which represents 40 to 50 percent of the physicians, the expenses necessary to maintain a practice approach 50 percent. So the expenses of maintaining a practice, an office availability, is considerable, and it is not possible to do that in a fee freeze environment.

Senator SASSER. Dr. Wright, thank you very much. And there are a couple of questions I'd like to ask you, but first let's hear from Mrs. Sasser.

STATEMENT OF GAYLA SASSER, EXECUTIVE DIRECTOR, TENNESSEE ASSOCIATION FOR HOME HEALTH

Mrs. SASSER. Thank you. I appreciate the opportunity to express views by the home care industry in Tennessee concerning the effect of Medicare cuts, and, unlike Dr. Wright, I have a little bit of a different opinion about how those effects have wreaked havock on our industry and are going to continue to do so.

The Tennessee Association for Home Health does represent approximately 200 member home care agencies statewide, and those agencies are private, nonprofit, public, government, hospital-based, and proprietary, so we have just about every kind of ownership you can imagine.

FUTURE OF HOME CARE INDUSTRY IS BLEAK

I would like to begin by saying that the current posture of Medicare does not leave the home care industry with the hopes of a very promising tomorrow. We feel our future is bleak in terms of reimbursement and operating capital for our agencies and our ability to provide accessible and quality services to the home care patients we serve. Our portion of the Medicare budget is minimal,

and yet it seems we are being hit the hardest and the fastest of any of the health care alternatives. Our services have been accepted by the public and the demand for our services is great, with 90 percent of the home care patients being Medicare beneficiaries. And yet, on July 1 of this year, new costs caps were enacted by the Health Care Financing Administration. Every health care agency whose fiscal year began July 1 is already under these new cost caps. And the effect of the new Medicare cost caps is an apparent overall decrease in allowable home care cost, and particularly in the rural areas of our state.

We accept the fact that this year the health care industry has in general had rates frozen. That has not been the case in home health. It has suffered a significant decrease, along with new cost caps, and let me see if I can explain briefly what cost caps mean to home health. We are reimbursed at our cost. However, our costs cannot exceed Medicare's cost caps. So if it costs us more to provide a particular service than the cost caps allow, that cost has to be taken up somewhere else.

CAPS PREVENT SPREADING OF COSTS

In the past, what we have been able to do is spread our costs from one service to another. We have rehabilitation services that are normally more expensive. Those are physical therapies, speech therapy, occupational therapy. We could in the past perhaps spread our nursing and home health aid cost over those higher cost disciplines and still be able to provide the services. The significant cost cap provisions were doubled in confusion by also changing the accounting methodology, so that now we cannot spread our costs. If the cost cap for nursing is $50, that's what you have. If your physical therapy cost cap is $50, that is what you have to provide that service.

I would like to tell you that a chart published by HCFA described the impact of these limits, set at 120 percent of the mean per visit of agencies over the cost caps. Hospital-based home health agencies are over the cost caps at 79.5 percent. Freestanding home health agencies are over the cost caps at 69.3 percent. For an average of all the home health agencies, 70.9 percent. It's also important to note that HCFA proposed all three of the changes I've described in the May 14 Federal Register.

On July 5, HCFA again published in the Federal Register these changes and announced that these significant changes were effective on July 1.

HCFA emphasizes that the behavior of home health agencies would change due to the new cost caps and accounting methodologies. Apparently that behavior will not be preplanned as HCFA allowed no time for planning, and in Tennessee the home care agencies are struggling to change behavior at a time when more and more home care patients are demanding services and more high-technological expensive services.

The October 1, 1984, DRG payment system, which has been discussed at length here today, imposed on hospitals has brought about earlier discharge of patients, and therefore sicker patients are being referred to home care. That sicker patient is in need of

highly skilled services, the services that HCFA now expects us to efficiently provide with no increase in reimbursement.

The home care industry is responding to the demand for highly skilled services, and now in a matter of a month and a half must also determine ways to continue those services at much less expense to the Medicare trust fund.

CHANGE IN MEDICARE INTERMEDIARY PROMISED

In addition, HCFA holds over our head the promise of changing our Medicare intermediary and piece-mealing the reimbursement, claims processing, and policymaking of our Medicare reimbursement by October 1 of this year. The effect of this proposed change will add to the confusion currently being faced by the home health agency, the beneficiary, and the intermediary.

An example for you would be that Blue Cross/Blue Shield of South Carolina has been tentatively named as Tennessee's new fiscal intermediary for Medicare. Currently that particular Blue Cross/Blue Shield intermediary has 40 home health agencies. In Tennessee, we have 390 home health agencies.

You can see that the adjustments for accepting that many more home health agencies on an intermediary is going to be rather burdensome.

Since the July 1 effective date of the new HCFA cost regulations, agencies are exploring behavior changes, and these tentative changes include, No. 1, layoff of personnel in high-cost-cap disciplines and, as I said earlier, those would normally include your rehabilitation services, physical therapy, speech therapy, occupational therapy, and medical social services; No. 2, discontinuance of high cost services; No. 3, lowering the amount of free care or indigent care provided; No. 4, using less highly skilled personnel to provide services formerly provided by a highly skilled employee; No. 5, selling and closing of agencies.

EFFECT OF BEHAVIOR CHANGES WILL BE FELT

Will these behavior changes affect the Medicare trust fund dollars or will the cost just simply shift back to the hospital, the physician, the nursing home or clinics? Will the behavior changes affect the homebound Medicare patient who cannot travel to another health care alternative for services? Will the homebound stroke patient simply lose his voice because no speech therapy can be provided to him in the home as efficiently as HCFA desires? Will the home care industry be stymied in developing high-cost, high-skilled services for early hospital discharges? We feel the answers are consistently "yes."

By HCFA's own standards, 70 percent of the home care agencies will be over the new cost caps in various disciplines. Then what is the answer to reducing cost and yet developing our home care industry which provides humane service to beneficiaries in the home environment? We feel that first the delay of the new accounting methodologies for at least a year would allow the home health industry to adjust to the new cost caps. The industry could then develop new record-keeping and efficiency measures in a health care planning mode rather than in a frenzied panic.

We also feel that delaying the selection process has allowed intermediaries to prepare, in dollars, personnel and training, for the new onslaught of responsibilities they face. And last, we suggest that the development of the prospective payment system for home health agencies be started and be based on collected and informed data.

The pilot programs for the DRG system for home health were supposed to begin in July of this year. They've been stopped. And we wonder why. If the prospective payment system is to be imposed on home care, and we understand that it is, we suggest that spending our time, energy and tax dollars in developing an efficient program, one that serves the beneficiary, the home care provider and the Government, be developed now. We suggest that perhaps the piece-mealing effect of trying to save tax dollars or trying to save money in the Medicare trust fund is not productive at this time, and we hope that the suggestions we've outlined will be acceptable and that you can support these in Congress for us.

BETTER HEALTH CARE POSSIBLE WITHOUT INCREASE IN COST

Senator SASSER. Well, thank you very much, Mrs. Sasser. Let me direct a couple of questions here.

Dr. Wright, you made the interesting observation a moment ago that you believe the goals of accessibility and quality health care with less than greatly increased cost were achieveable now and into the future. I think you mildly disagreed with one of our witnesses who preceded you who indicated, as you know, that the three were mutually exclusive, that is, accessibility, quality health care, and reasonable cost. Tell us how we can reach that goal, or how do you think we can reach the goal that you laid out there, other than through taking better care of ourselves, which I think people are doing now, and particularly of younger people in great numbers.

Dr. WRIGHT. That may sound very ambitious and hopefully is not taken out of context. When we are talking about billions of dollars being spent on health care at the present day, it is my considered opinion that the same health care, the quality health care, the accessible health care, can be obtained for a lesser expenditure. As time goes on, obviously all things tend to increase in cost, but in using my thoughts and projections in a general way, I still think that, for the foreseeable future, for the same dollar, we could get better health care out of it if we use it wisely.

It's interesting that in 1984 to 1985, with the DRG's, the fee freeze, the PRO's and other mechanisms that have caused consistent and significant decreased utilization, there has been some discussion about the decrease in quality, but I personally have not seen this.

Now as time goes on, if the costs are continually cut and accessibility to the institutions, the hospitals, the doctors' offices are closed, then obviously quality would fall. But I don't think that's going to happen. That's my——

Senator SASSER. Well, I hope you are correct about that. And that's an optimistic statement you made, and I tend usually to be an optimist. I am concerned, quite frankly, about the fact that our

population continues to age, and the fact that medical care and medical treatment becomes increasingly sophisticated as we move into this very high technology era with regard to treating patients and medical problems, which is a blessing, we are all grateful for it. But it is very, very costly, as you know. And if you would like to collect your thoughts at some time at your leisure and make some suggestions to those of us at the Federal level, of how we could maybe better shape and craft the Medicare Program and others so that we could guarantee good accessibility and good quality medical care at a reasonably attainable cost, I'd be very much interested in hearing from you.

I suspect I know one item that you would bring up right away, and that is the cost of medical malpractice. I hear that from physicians all across our State who think that the cost of medical malpractice judgments have now become exorbitant and the cost of insurance coverage has been increasing health-care costs to the patient. I assume you agree with that, Dr. Wright?

MALPRACTICE INSURANCE COSTS

Dr. WRIGHT. Without question when we talked earlier in our opening statement about the health-care costs rising 400, 500 percent in a certain period of time. When I went into practice a few years age my malpractice expenditures for premiums was something in the neighborhood of $600, and now it's in the neighborhood of $18,000, so that represents a considerable increase in inflationary spiral. The reasons for this are very complex, I don't fully understand them, and I don't certainly have any short term quick solutions to that problem. But it is an expense that is real, and it has to be considered, especially in the light of fee freezes——

Senator SASSER. Well, there has been an explosion in that. I remember some years ago, when I was practicing law here in Nashville, there would be no more than three or four medical malpractice cases in this whole country at any one time, and judgments were extremely rare, adverse judgments against physicians were extremely rare in those days. I'm talking about 12, 15 years ago. But that's changed very, very dramatically, and I note one of the popular publications has indicated that my former colleagues in the leal profession have now begun to sue each other for malpractice. So that might have a very salutory effect in the long run in reducing malpractice cases in general.

One final question, Dr. Wright. As a physician, in your judgment, what are the full consequences as you see them of the implementation of the DRG Program with regard, No. 1, to reduction of medical costs, and No. 2, how that might impact on the quality of health care available to recipients?

Dr. WRIGHT. Well, I've heard testimony today that I basically agree with, if again taken in the proper context. As it stands in 1985, we don't have enough experience with DRG's to actually make a statement as to the effect on quality accessibility. It would be a projection or a prediction, if you will. If my numbers are acurate in this area, most of the hospitals are either on a 25-percent or a 50-percent possibly DRG, gradually going into the 100-percent

DRG concept over a period of 3 years. So at this point it's I think impossible to tell.

Now there are some patients, how many and exactly what categories of DRG, that is a losing proposition. You cannot take care of some people's problems for the amount of money allocated under DRG number number number. Some DRG's are probably appropriately categorized and compensated. I think that time will tell us, and we need the flexibility to change when change is needed. To me there is no question that some individuals with complex problems need care, deserve care, and the DRG does not allow that under the present number system. So I think, as we go along, we must be flexible enough to change this as needed.

FULL IMPACT OF DRG APPROACH UNKNOWN

Senator SASSER. On balance, would you say that the DRG approach is worthwhile or not?

Dr. WRIGHT. I think it's been an educational effort up to this point, and I must reserve my final opinion about DRG's until I see the full impact as to what it causes. I don't belive that we can necessarily project doom into a system without having tried it. Even in New Jersey and some of the other areas that have been dealing with the DRG's, I've heard conflicting reports about the success and failure of it. So I don't think we can really say with accuracy what the DRG is going to be.

Senator SASSER. I agree with you. I think the jury's still out on the whole DRG concept. I think we can say that it has been effective to some degree in reducing health care cost; how much it's difficult to determine. I think we'll still have to wait and see what it's done to the quality of medical care over a period of time.

Dr. WRIGHT. I think that the education that I spoke of is one of the factors in this. In years past everyone talked about medical care cost as if it were a sacred issue, and you only discussed it with your family or close friends, and no one really openly said, well, I forgot to ask the doctor's fee, et cetera. I had a gentleman not too long ago who was asking me about his proposed surgical procedure, and he said, well, let's see, doctor, oh, yes, I'm supposed to ask you this, how much is it going to cost? And we discussed that. And he said, well, I didn't really want to know; I was just told to ask.

So in my experience, very little discussion is taking place with how much medical care is going to cost. And I think, in our modern-day environment, it has caused all of us to think about this in an objective way, and in turn has served as an educational effort, and I think we will all benefit from this if we look at the data and assimilate them and use them appropriately.

Senator SASSER. Well, I must say that your patients may not want to discuss the cost with you, but they have no reluctance to discuss health care costs with me and I suspect others who represent them, because I hear it at almost every stop, and it's not just a question of physicians' fees, it's the whole constellation of health care cost, and we are starting to hear it now from employers complaining about what they consider to be the excessive cost of health insurance plans for their employees.

One final question for you, Mrs. Sasser. In your judgment, how can home health care improve the quality of our health care system and at the same time keep health costs down?

Mrs. SASSER. Well, No. 1, I think we can improve the quality of care of our elderly in particular by providing care to them in the home. The dignity level of the elderly is kept at a higher plane by being in the home environment, within their own surroundings, than out in the institutional setting. I forgot the last part of your question.

HOME HEALTH CARE MOST COST EFFICIENT

Senator SASSER. The last part is how can home health care keep health cost down?

Mrs. SASSER. Well, there have been a lot of studies done on home care, comparing the cost from hospital to nursing home to home care, and so far it has been projected as the most effective alternative to institutionalization. So I think that we began as a cost effective alternative, and I think that we can continue to do that if we are allowed to perhaps help the Government in looking at perspective pay for home health, and in trying to perhaps take home some of the experiences that the hospitals have gone through on perspective payment, and not repeat problem areas, but used as factors in developing our own perspective payment system, because we do want to be cost effective as well as quality-care oriented.

Senator SASSER. Well, thank you very much, and thank you Mrs. Sasser, and thank you Dr. Wright for taking time out of your very busy schedule to give us the benefit of your views.

The testimony that we've heard here today I think has been informative and enlightening, and these remarks will be printed in full in a congressional hearing record, and anyone who wishes to submit additional information may do so.

We will hold the record open until September 30, and additional information can be sent to my office here in Nashville located in the U.S. Courthouse on Broadway, room 569.

I think in summation, what we have heard here today from beneficiaries and those who represent benefiticiaries under the Medicare system, is that Medicare is leaving a lot of holes through which many elderly patients are falling and not getting the adequate medical care that they had been led to believe in prior years would be available to them under the Medicare system. As the Medicare system has felt increasingly cost pressures brought about by escalating health care cost, as the population has continued to age, we have seen a continual narrowing of Medicare coverage, and efforts sometimes misguided, sometimes effective, to make the Medicare system more cost efficient. And the bottom line has been that some beneficiaries have simply not been getting the type of health care through the Medicare system, paid for by the Medicare system, that they had hoped.

HEALTH CARE IN STATE OF TRANSITION

We have also heard from careerists in the field of hospital administration who detailed that in their judgment health care is in a state of transition in this country, and I think that is indeed the

case. A case has been made that the three facets of health care quality, accessibility, and reasonable costs are mutually exclusive at the present time. That has been called into question by at least one expert who testified before us today. But I think generally there is great concern as to whether or not we can continue to deliver to our population quality health care that all will have available to them at a cost that we can afford in this country, one with the most wealthy economy and the largest gross national product by far of any nation in the world.

I think we are going to find that the question of quality health care at a reasonable cost is going to be a continuing national dialog in this country. What we've heard today I suspect is just the tip of the iceberg, and this dialog regarding quality health care that is accessible and affordable is one that will continue throughout this decade and I think well into the decade of the 1990's, and we see how our health care delivery system and how our Federal Government fits into that health care delivery system is a state of I think significant transition.

During this period of time I think it's incumbent upon those of us at the Federal level to continue to work toward and maintain the solvency of the Medicare Trust Fund, and I pledge to do that, and at the same time to still work for a system that can provide quality medical care that will be available and affordable to all of our Medicare/Medicaid beneficiaries, and hopefully to all individuals.

With those few words of dubious wisdom, I'll declare these hearings closed, and thank all who participated, and my particular thanks to our witnesses who appeared here today. Thank you.

Impact of Cost Containment on Access to Long Term Care Services

Statement by
Karen Struve, President
Walker Methodist Residence
and Health Services, Inc.
Minneapolis, MN

before the
House Select Committee on Aging
July 9, 1985

Mr. Chairman and Members of the Committee

I am Karen Struve, President of the Walker Methodist Residence in Minneapolis, Minnesota. I am here today on behalf of the American Health Care Association (AHCA) and the American Association of Homes for the Aging (AAHA). More important, however, I am here on behalf of the thousands of elderly and needy Medicare beneficiaries who are daily being denied care in skilled nursing homes because of cost reductions directed from Washington. Most of these people are too frail and sick to come here and tell you about their problems. If they could, they would tell you about how impossible it is to receive coverage from intermediaries who are deciding arbitrarily that they are ineligible for skilled coverage in contravention of the Medicare law and about the difficulties they are having in finding nursing homes which will accept them because the homes have lost their Medicare waiver of liability.

The elderly have truly become victims of a system in which they are discharged earlier, and sometimes prematurely, as a result of the new hospital DRG payment

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system, yet cannot obtain the post-hospital benefits to which they are entitled and which they desperately need now more than ever. The concerted effort by the Health Care Financing Administration (HCFA) to deny Medicare benefits to the elderly is similar to the Administration's ill-founded attempts to purge the disability rolls several years ago in the name of cost savings.

Our two associations recognized that the problems with Medicare rules were driving nursing homes out of active participation in the Medicare program and leading to access problems for the beneficiaries. Both associations have joined with a coalition of consumers and providers on the waiver of liability issue. The drastic steps taken by the Administration to virtually eliminate the skilled nursing facility (SNF) benefit has lead to an effective bonding of interests between consumers and providers. We commend the Committee for its attention to this vital issue and fervently hope that this hearing will serve as the catalyst for initiating action to resolve these issues.

There are 2 major Medicare problem areas which we would like to address today:

1. Coverage Issues
2. Proposed Freeze on SNF Reimbursement

Coverage Issues

The low numbers of individuals qualifying for Medicare skilled nursing facility care has been a problem since the early 1970's, but today it has reached

crisis proportions. While Congress intended the benefit as an extension of a hospital stay for patients needing skilled nursing or rehabilitative care, the current Administration has so narrowly construed eligibility, that we frequently have terminally ill patients being denied coverage. My own facility in Minnesota has gone from 190 certified Medicare beds to only 10 because there were never sufficient patients who could meet the overly restrictive eligibility criteria for Medicare set out by the intermediary. Patients who require 24 hour skilled care or skilled nursing supervision are not permitted coverage, even though the law specifies they should be. Our intermediary only grants coverage to patients who have rehabilitative potential, obviously not a feasible goal when you are dealing with an 89-year-old patient admitted for gastrointestinal hemorrhage, multiple peptic ulcers, arteriosclerotic heart disease and who is legally blind and deaf.

On the other hand, when there is a possibility of rehabilitation potential, nursing homes in Pennsylvania and throughout the nation report that coverage for rehabilitative care such as physical therapy, is not granted because the intermediary insists it should be delivered in the home, regardless of the patient's other medical needs or family situation. As a case in point, the intermediary in Illinois terminated coverage after less than a week on an 84-year-old patient with a broken hip and a broken wrist. The patient's arm was in a cast, she lived alone with only an elderly sister nearby. She still required physical therapy, yet she could not function in her home with a walker because of her wrist.

There is no question that intermediary coverage decisions under the SNF

Medicare benefit are grossly inconsistent, imprecise, and biased. The arbitrary administration of the benefit is revealed by the 80 percent rate of reversal in successful reconsiderations brought by the Connecticut Legal Assistance to Medicare Patient Project, and has been well documented in a study published in the New England Journal of Medicine, which showed how different intermediaries interpreted Medicare SNF coverage inconsistently for 9 hypothetical cases. The authors concluded:

> Medicare coverage for skilled nursing care is not a clear cut, predictable benefit from either the physician's or the beneficiary's point of view. Instead, it is highly unpredictable and dependent on criteria that are often implicit, unwritten, and not available for perusal or comment. Differences in criteria and the application of rules of thumb must inevitably lead to disagreement not only on coverage, but on the reasoning behind reward or denial.

In a survey just completed by AAHA and AHCA, of 1000 skilled nursing homes certified to serve Medicare patients, only 3.7% of the more than 22,000 beds were occupied by Medicare patients. Thirty-five percent of the homes had no Medicare patients at all.

National data confirm the serious access problem for older Americans. In 1980, one-half of the non-metropolitan counties and 17% of the metropolitan counties lacked any certified skilled facilities at all. Thirty percent of SNF patient days are concentrated in only two states, New York and California and 50% of the patient days are delivered in only six states. Total SNF Medicare

covered days declined by over one half between 1969 and 1977. The impact on the beneficiary is equally alarming: a 21% decrease in the covered days per thousand beneficiaries occurred between 1976 and 1982. This is tantamount to a 21% cut in benefits at a time when eligible Medicare beneficiaries increased 20.3%.

The current waiver law is critical to the Medicare SNFs because it provides some protection against the kinds of retroactive denials of coverage that motivated over one half of the nation's nursing homes participating in Medicare to leave the program. The waiver of liability guidelines were passed by Congress in 1972 in direct response to providers leaving the program.

With this bleak picture as a backdrop, the Administration has now taken steps to wipe out any remaining vestiges of the Medicare SNF program. On March 14, 1985, it proposed eliminating the waiver of liability, a provision which has afforded nursing homes and other providers a cushion for coverage denials made in eligibility determinations. Under the statutory provision, the waiver provides relief to a beneficiary or provider who acted in "good faith" in accepting and providing services, later found by the intermediary to be not reasonable or necessary. Making these determinations is often impossible because the grey areas are larger than the black and white. For providers to be held liable for their "good faith" effort is simply ludicrous. Having the waiver has enabled many providers to remain in a program that has few, if any, incentives to be in it in the first place.

Not content to rely solely on eliminating the waiver to achieve benefit

cuts, HCFA has also recently changed the way it calculates waivered days. Previously, a skilled nursing facility's denial rate was calculated by dividing the number of Medicare days provided into the number of days denied by the intermediary. If this figure was below 5%, then the nursing home was able to maintain its waiver and the denied days were paid for by Medicare. The new methodology, rather than using the total number of Medicare days in the denominator, uses a sample of cases which are supposedly representative of the total, to project a sample denial rate. Too often these samples are not at all representative or random, for they focus on the grey area cases. Lewin and Associates found the problems with the projection methodology "so severe that they completely invalidate the methodology, making it unusable as a basis for denying presumptive waivers of liability."

The effect of this supposedly minor administrative change provides an alarming preview of what would happen if the waiver were eliminated altogether as HCFA has proposed. Within the last 6 months, scores of facilities have lost their waivers for the very first time as a result of these changes. One large group of facilities which lost their waivers reported experiencing a decrease in Medicare utilization by up to 50% at individual facilities and an average 28% decrease within the group.

These figures are also reflected in the AHCA-AAHA survey wherein 43% of the respondents reported that their intermediary coverage decisions had grown stricter within the last year. We asked these providers what actions they would take if the waiver were eliminated altogether and 16.5% said they would drop out of the program completely. Respondents reported they would reduce Medicare

admissions by an average 26.2% and decrease days submitted for coverage by 28.1%.

It is no mystery why HCFA has changed its sampling procedures: every beneficiary denied services equals dollars saved by the program. One intermediary in the midwest has told providers that the intermediary is having to pay for its past errors by showing a month by month reduction in Medicare patient days. As a consequence, the provider responding to our questionnaire had experienced a 75% reduction in Medicare-covered patient days since May 1984.

An analysis of HCFA's new sampling process by Lewin and Associates, an independent consultant, found "errors and omissions" representing violations of "fundamental and elementary principles of statistics". It would seem that HCFA will stop at nothing, including rewriting the laws of statistical sampling, to achieve its cost savings goals. We estimate that nationwide, one-half the providers who currently have waiver status are likely to lose them unjustly as a result of these sampling changes.

Mr. Chairman, this country has come to a sad state of affairs if the Department of Health and Human Services has to cheat the elderly out of their benefits in order to save money. AAHA and AHCA call on HHS to halt this ill-conceived sampling process.

In addition to problems with the waiver of liability and sampling methods, the whole contractual relationship between the Health Care Financing Administration and intermediaries is worth discussing briefly, for it brings serious questions to mind.

For example, just like traffic cops who are expected to write a certain quota of tickets, a priority consideration in the evaluation of intermediaries by HCFA is the dollars saved by reducing utilization versus dollars expended in achieving those reductions. Element 16, of Sub-Section 2901.1 (Contractors Performance Evaluation Program) of the Health Insurance Manual (13-2) set this ratio as a minimum of 5-1, that is, an intermediary must save $5 in utilization reductions for every dollar of its administrative cost. If the intermediary falls below this ratio, it is in jeopardy of having its contract terminated by HCFA. Ironically, it is to the benefit of the intermediary to deny coverage in order to meet its quota, because if the case is later overturned, it is not charged back against the intermediary's quota.

Another potential conflict of interest exists for intermediaries which also offer Medigap insurance. Essentially this is private insurance purchased by the elderly which supplements Medicare, but the policyholder does not qualify for it until he or she becomes eligible for Medicare. Thus the intermediary is placed in the potentially conflicting positions of determining eligibility for Medicare benefits which could also result in additional expenses to the intermediary through payout on the Medigap policy. This circumstance provides a double incentive for intermediaries to deny coverage: it helps them meet their quota for cost effectiveness and it saves them from paying out on the private insurance policy themselves.

The beneficiary is truly caught in a no-win situation by the Department's efforts to reduce services and utilization. The most unfortunate part is that

the need for these services has reached a critical point thanks to the earlier discharges precipitated by the hospital DRG payment system. We must not abandon the elderly to their own devices. The Medicare SNF coverage issue must be met head-on and a solution found before it is too late.

One solution that we propose is the reinstitution of front end review in which the intermediary approves coverage for a patient at the beginning of his stay for a specific number of days. Recertification would take place for additional days if appropriate. This approach was used with some success about ten years ago and since it affords both the provider and the beneficiary some measure of protection against retroactive denials, we believe it is worth considering.

Freezing the SNF Cost Limits

The Administration has proposed freezing Medicare Section 223 cost limits for all providers, including skilled nursing facilities. This freeze would serve only to exacerbate the access problems that already exist in SNF's. Despite the fact that Congress, in enacting the Section 223 cost limits, stated that the limits would apply to a relatively "small number of institutions" and only in "cases with extraordinary expenses," more than two-thirds of the facilities in states with high rates of participation were being constrained by the cost limits last year. The percentage is, no doubt, higher this year due to the greater intensity of services needed by patients discharged under the hospital DRG system. Fully two-thirds of our survey respondents reported an increase in the acuity level of Medicare patients, with over 56% reporting an increase in the demand for SNF Medicare services. Those facilities are losing money

every time they admit a Medicare patient and can hardly be blamed if they drop out of the program.

The HCFA SNF prospective payment report also showed that homes with greater involvement in the SNF Medicare program had significantly higher costs than average. Our survey fully supported these conclusions, for 87.5% of those providers with 10 or more Medicare patients reported that they were already at or over the Section 223 limits. As the HCFA report recently stated, "For these facilities and those approaching the cost limits, the current system rewards providers who serve light care patients because the higher costs for treating heavy care patients are not recognized in the flat rate per day retrospective reimbursement limit system in effect."

A variety of sources, including our own survey, documented the greater need for more intensive skilled care that has arisen because of the DRG prospective payment system. Three recent studies have shown that patients were being discharged sicker and quicker from hospitals; a study by the National Center for Health Services Research, a survey of states ombudsmen, and a preliminary GAO report. In addition, a June 25, 1985 article in the Wall Street Journal described some of the problems these patients were having in obtaining the post-hospital care they needed. Senator John Heinz referred to this state of limbo for the Medicare patients as the "no care zone." We ask that it be made part of the hearing record.

It should be noted that nursing home costs have never contributed to the Medicare cost containment problem and very little savings would result from

freezing the SNF portion of the budget. Unlike hospitals, increases in Medicare expenditures and per diem costs for SNFs have been consistently below the rate of inflation. Additionally, expenditures on nursing homes now constitute less than one percent of total Medicare spending--down from 6.2 percent in 1967--significantly lower than payments to physicians or home health agencies under the program, and even lower than the error rate in payments to hospitals. Projected savings of $5 million from a freeze of the SNF Medicare budget not only ignores the increases in total Medicare spending that would result, but also fails to consider the tremendous difficulties that beneficiaries would face in not receiving the appropriate post-hospital services they now so urgently need.

While coverage is being restricted and sicker patients are in desperate need of care, already inadequate reimbursement rates are being ratcheted down to a point where quality rehabilitative care cannot be provided without incurring financial loss. For the vast majority of providers across the country, these barriers to participation are prohibitive, and beneficiaries systematically are denied the care they have been promised.

Recommendations:

Certainly the opportunity to air these problems in a public forum is a first step towards their resolution, but only a first step.

Both AAHA and AHCA have been fortunate in working with a coalition of 17 concerned provider and consumer groups, such as the American Association of Retired Persons and the National Council of Senior Citizens, on the waiver of

liability issue. The makeup of this coalition underscores the fact that this is a beneficiary issue as much as a provider issue. The group has met with HCFA requesting a postponement of the final regulations until an assessment of impact can be made. In addition, your Committee, Mr. Chairman, and the Senate Aging Committee have sent a letter to HHS Secretary Heckler asking the Department to assess the impact of the provision upon beneficiaries before taking any further action.

Here are the goals that AHCA and AAHA seek:

- HHS should not proceed with final regulations to eliminate the waiver of liability.

- The new "sampling" procedure should be abandoned. Any methodology employed should meet general principles of statistical sampling, and be fair in their application.

- Intermediary incentives for coverage denials, quotas, etc., should be eliminated.

- The General Accounting Office should undertake a short term study on Medicare SNF coverage and eligibility problems, including variations among intermediaries, HCFA/intermediary contractual relationships, denial rates, utilization changes, intermediary/insurer conflicts of interest, hospital readmission rates, etc., with recommendations for improvement.

- A blue ribbon panel should be established to report and make recommendations to Congress within one year on coverage under the Medicare SNF benefit.

- Periodic official publication of the facts of coverage rationale for a representative sample of cases in the "grey" areas, including observation, assessment, and overall management of patients with multiple problems. This information should be made available to the general public.

- Statistics on the administration of the skilled care benefits by individual Medicare intermediaries should be compiled to help facilitate intermediary performance review by HCFA.

- There should be a standardized program of training for intermediary personnel performing reviews to ensure that reviewers and their supervisors completely understand the criteria for coverage and the way these criteria are applied.

- Providers should be permitted to act on behalf of and as advocates for patients denied Medicare coverage.

- The feasibility of reinstituting front end review by intermediaries should be explored by HCFA and reported to Congress.

- Section 223 limits for skilled nursing facilities should not be frozen; HCFA should review the process through which nursing homes can obtain exceptions to the limits.

Mr. Chairman and members of the Committee, the efforts of this Administration to engage in a slashing of benefits to the elderly are irresponsible and ill-considered. The Department of Health and Human Services' own projections concerning hospital backup days portend a multi-billion dollar expenditure in the next five years: nearly 1 1/2 million Medicare backup days and 8 million Medicaid days of patients in hospitals awaiting nursing home placement. This translates into a minimum of $3.8 billion in additional program expenditures if the present policies are allowed to continue. We must prevent the Administration from breaking its promise to provide appropriate care for older Americans by denying access to those services the law says they are entitled to. We need your help to achieve this.

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STATEMENT BEFORE SENATOR JAMES SASSER,
HEARING ON MEDICARE CUTBACKS

TENNESSEE HEALTH CARE ASSOCIATION
AUGUST 30, 1985

WE APPRECIATE THE OPPORTUNITY TO ADDRESS THE EFFECTS OF MEDICARE CUTBACKS ON THE NURSING HOME INDUSTRY. FROM A NATIONAL PERSPECTIVE, THE AMERICAN HEALTH CARE ASSOCIATION HAS PROVIDED CONSIDERABLE TESTIMONY ON THIS SUBJECT AT HEARINGS IN WASHINGTON. WE ARE MAKING THOSE STATEMENTS AVAILABLE TO YOU.

IN TENNESSEE LESS THAN 3% OF THE NURSING HOME PATIENTS RECEIVE MEDICARE REIMBURSED SERVICES THROUGH SKILLED NURSING FACILITIES (SNF). DESPITE THIS LOW LEVEL OF MEDICARE UTILIZATION, CUTBACKS IN THE MEDICARE PROGRAM ARE HAVING A PROFOUND IMPACT ON NURSING HOMES IN THIS STATE.

FIRST, MEDICARE PRINCIPLES OF REIMBURSEMENT ARE USED BY THE STATE'S MEDICAID PROGRAM AND THERE HAVE BEEN SIGNIFICANT CHANGES IN THOSE REIMBURSEMENT PRINCIPLES WHICH HAVE AFFECTED OUR INDUSTRY. SINCE 65% OF OUR PATIENTS ARE MEDICAID RECIPIENTS IT IS EASY TO SEE THAT CERTAIN CHANGES IN MEDICARE WILL AFFECT OUR INDUSTRY THROUGH THE MEDICAID PROGRAM.

THE PRIME EXAMPLE OF SUCH A CHANGE WAS THE CONGRESSIONAL ACTION LAST YEAR "FREEZING" THE VALUE OF A FACILITY (FOR MEDICARE/MEDICAID REIMBURSEMENT PURPOSES) WHEN IT IS SOLD. THIS WILL HAVE THE LONG RANGE EFFECT OF DISCOURAGING INVESTMENT IN THE INDUSTRY. FEW PEOPLE WISH TO MAKE SUBSTANTIAL CAPITAL EXPENDITURE INVESTMENTS KNOWING IT MAY BE DIFFICULT IF NOT IMPOSSIBLE TO SELL THE ASSET FOR ITS APPRECIATED FAIR MARKET VALUE.

SECOND, MEDICARE CUTBACKS ARE MAKING IT MORE DIFFICULT FOR NURSING HOMES TO PROVIDE THE NEEDED SERVICES TO PATIENTS. THE MEDICARE HOSPITAL DRG SYSTEM IS FORCING PATIENTS OUT OF THE HOSPITAL QUICKER AND SICKER. WE AT THE ASSOCIATION CONSTANTLY HEAR OF PATIENTS BEING DISCHARGED TO NURSING HOMES

IN CONDITIONS THAT STILL MAY WARRANT MORE ACUTE CURE SERVICES. THESE PATIENTS ARE BEING DISCHARGED TO SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES AND HAVING THEIR CARE PAID FOR BY MEDICARE AND MEDICAID. WHILE NURSING HOMES ARE PROVIDING THE SERVICES NEEDED TO THESE PATIENTS THE PROVISION IS INCREASINGLY TAXING OUR ABILITIES UNDER THE RESTRICTIVE REIMBURSEMENT RATES WE RECEIVE FROM MEDICARE AND MEDICAID. WE ARE BEING ASKED IN MANY CASES TO CARE FOR AN ACUTE CARE PATIENT AT A MEDICAID INTERMEDIATE CARE PRICE. THIS IS NOT ONLY UNFAIR, IT IS UNWISE. THE NURSING HOME CAN NOT "ABSORB" THE ADDITIONAL COSTS OF CARING FOR THESE TYPE PATIENTS FOREVER. MODIFICATIONS IN THE MEDICARE (AND MEDICAID) REIMBURSEMENT SYSTEMS MUST BE MADE TO ASSURE SOME EQUITY, TO RECOGNIZE THE INCREASING COSTS OF CARING FOR THESE PATIENTS.

INSTEAD OF RECOGNIZING THESE ADDITIONAL DEMANDS BEING PLACED ON NURSING HOMES AND INCREASING REIMBURSEMENT TO COMPENSATE FOR THE ADDITIONAL CARE THAT MUST BE DELIVERED, THE REAGAN ADMINISTRATION CONTINUES TO PROMOTE SUCH COST CONTAINMENT MEASURES AS FREEZES OF MEDICARE PAYMENTS TO SNFs, REDUCTIONS IN MEDICARE EXPENDITURES BY INCREASING PATIENT'S COINSURANCE AND DEDUCTIBLE LIABILITIES AND FURTHER CUTS IN MEDICAID. INCREASES IN PATIENT COINSURANCE AND DEDUCTIBLES CREATES SITUATIONS WHERE SOME PEOPLE CAN NOT GET NURSING HOME CARE. THOSE PEOPLE MAY NOT BE ELIGIBLE FOR MEDICAID, BUT NOT HAVE ENOUGH INCOME TO BUY "MEDIGAP" INSURANCE NOR AFFORD THE OUT-OF-POCKET EXPENSE THAT MUST BE INCURRED ONCE MEDICARE STOPS PAYING THE FULL BILL, AFTER THE FIRST 20 DAYS IN AN SNF.

THIRD, MEDICARE CUTBACKS ARE FURTHER AFFECTING NURSING HOMES BY DIVERTING

PATIENTS AWAY FROM NURSING HOMES AND FORCING OTHER HEALTH PROVIDERS INTO LONG TERM CARE, MAKING IT MORE DIFFICULT FOR PATIENTS TO GAIN ACCESS TO NURSING HOMES. HOSPITALS, FOR EXAMPLE, ARE ADDING SKILLED CARE BEDS, TRANSFERING PATIENTS TO THEIR OWN SKILLED UNIT TO BEAT THE DRG SYSTEM. OUR CONCERN HERE IS TWO FOLD, ONE THAT HOSPITALS, UNACCUSTOMED TO LONG TERM CARE PATIENTS MAY NOT PROVIDE THE FULL RANGE OF SERVICES (SOCIAL, MEDICAL AND NURSING) NEEDED FOR THESE PATIENTS, AND MAY HAVE A TENDENCY TO DISCHARGE PATIENTS TOO SOON EVEN FROM THEIR SKILLED UNIT. SECOND, WE SEE THE TRADITIONAL REFERRAL PATTERNS CHANGING. HOSPITALS WILL NO LONGER REFER PATIENTS TO NURSING HOMES BUT RETAIN THEM IN THE HOSPITAL, DISCHARGE THEM AND THEN REFER THEM TO THEIR OWN HOME HEALTH AGENCY. THIS CHANGE IN REFERRAL NOT ONLY AFFECTS OUR PATIENT CENSUS BUT WE BELIEVE WILL HAVE LONG RANGE DAMAGING EFFECTS ON PATIENT CARE. OFTEN A PATIENT NEEDS THE SERVICES OF A NURSING HOME UNTIL THEY ARE CAPABLE OF LIVING AGAIN AT HOME. INSTEAD WE SEE THESE REFERRAL PATTERNS SENDING THE PATIENT HOME, UNCAPABLE OF LIVING THERE EVEN WITH ASSISTANCE FROM A HOME HEALTH AGENCY.

INCREASINGLY, WE ARE SEEING PATIENTS DENIED NURSING HOME COVERAGE BY THE MEDICARE INTERMEDIARY UNDER THE GUISE THEY CAN BE CARED FOR AT HOME. WHILE THIS MAY RESULT IN MINIMAL SHORT RANGE SAVINGS IT FREQUENTLY WILL RESULT IN MORE RAPID DETERIORATION OF THE PATIENT AND EVENTUALLY MORE EXPENSIVE REHOSPITALIZATION.

THESE ARE A FEW OF THE AFFECTS OF MEDICARE CUTBACKS AND WE APPRECIATE THE OPPORTUNITY TO ADDRESS THEM TODAY.

Statement of the American Health Care Association

PROSPECTIVE PAYMENT FOR
CERTAIN PHYSICIAN ACTIVITIES IN MEDICARE

BY

Paul Willging, D.D.
Deputy Executive Vice President

BEFORE THE

Committee on Finance
U.S. Senate

April 17, 1985

ahca
American Health Care Association 1200 15th Street, Washington, DC 20005 (202) 833-2050
For Further Information Contact:
Jay Greenstreet

Mr. Chairman and Members of the Committee:

I am Paul Willging, Deputy Executive Vice President of the American Health Care Association. AHCA is the largest association of Medicare nursing home providers.

This Committee has acted responsibly in reforming the Medicare payment method for hospitals. You moved hospitals off retrospective, cost reimbursement in 1982 to a target rate program and then in 1983 to a 3 year phase-in of the diagnostic-related group (DRG) prospective payment system. I urge you to begin the logical step of implementing a similar phase-in of a prospective system for Medicare skilled nursing facilities (SNFs).

The evidence is overwhelming that the Medicare SNF system is broken, but it can be fixed. There is an increasing need for action on SNF prospective payment and initial, important changes can be made now to improve the situation for beneficiaries, taxpayers, and providers. The problems of patient access to needed SNF services, already acute in many areas of the country, are worsening because of DRG impacts and an outmoded payment methodology. Even before DRGs were begun for hospitals, we urged action on implementation on a prospective payment system for SNFs. That step is increasingly important as the DRGs are phased-in not only because of the incentives for more patient transfers to SNFs, but because of earlier transfers involving sicker patients.

I would like to highlight the major failings of the present system and then suggest what can be done <u>now</u> so as to lay the groundwork for achieving the benefits of an ideal system.

The major failings can be summarized as the following:

Obstacles to Patient Access to Services

- Low provider participation in Medicare. Less than 1/3 of the nursing homes have even sought Medicare certification. A major reason for provider reluctance is the complexity of Medicare reimbursement. Many providers initially in the program have terminated participation.

- Geographic disparities in Medicare SNF availability:
  - Only 25% of the SNFs are in rural areas.
  - 30% of SNF patient days are concentrated in 2 states, 50% in 6 states.
  - 9% of the SNFs provide fully 40% of patient days and 40% of the SNFs provide only 9% of the patient days.
  - Beds average 18/1000 elderly beneficiaries, ranging from 1 (Arkansas and Oklahoma) to 51 (North Dakota).
  - Patient days average 310/1,000 elderly beneficiaries, ranging from 1 day (Wyoming) to 635 days (Kentucky).

- Increasing demand for SNF beds. This is a direct impact of DRG incentives for hospitals to discharge patients in greater numbers to SNFs.

- Financial disincentives for admission of "heavy care" patients. This longstanding problem is worsening with the DRG incentive for earlier hospital discharges.

Obstacles to Delivery of Services Cost-Effectively

- No incentives for provider efficiency.

- Unnecessary payments, even with DRGs, for patients "backed-up" in hospitals awaiting SNF placement.

To those who suggest that nothing should be done this year about SNF payments, I would remind them that the Administration is suggesting something should be done this year. Unfortunately, their suggestion is the counter-productive step of freezing SNF reimbursement. The possibility of Congressional approval of the Administration's SNF payment freeze, even for one year, will inevitably worsen patient access and undermine DRG success. With such possibilities, we cannot afford to wait until all the research questions are answered.

What we offer is a constructive and cost-effective way to deal with the SNF payment method problems. To those who claim that there are not sufficient data and experience to change, I would say first that there are sufficient data and experience to know that the present method fails everyone. We know enough to begin to move now! A transitional program is an expeditious way to develop the precision and refinements of an ideal system.

If Congress is to exercise its responsibility in establishing nursing home reimbursement policy and introducing concepts of cost containment and improved patient access, it should act now. Considerable experience is available from state Medicaid nursing home reimbursement systems to determine which system features will work and which will not. While Medicaid and Medicare patients are different, we know enough from our Medicaid system to structure an improved and workable interim system for Medi . Medicare-specific patient data are only now being acquired by HCFA. This transitional prospective system can then be modified as the findings of the ongoing research become available.

Prospective payment has successfully served as the foundation of Medicaid nursing home reimbursement for many years and Medicaid pays for 30 times more nursing home patient days than does Medicare. We share your frustration that the Health Care Financing Administration has ignored the Congressional mandates for recommendations on a prospective payment plan for the much smaller Medicare SNF program.

I can appreciate that members of this Committee may have ideas on how they would structure such a system; we have our ideas as well. While I believe there is general agreement that the ultimate system should relate reimbursement to individual patients' needs, I would agree with the Department that data are not available at this time to adopt the "perfect" plan. The transitional approach recommended by the American Health Care Association maintains the flexibility necessary for Congress to make adjustments without delaying the first steps toward a prospective system. Our transitional approach establishes a very solid base upon which a final system can be built. The Medicare DRG payment for hospitals underscores the need to adopt a transitional prospective system for SNFs now, rather than waiting for completion of ongoing research to develop the "perfect" system.

In brief, AHCA's recommended transitional system features the following:

- Prospective rates covering all operating and most direct patient care expenses. Rates would be based on a facility's reported costs, indexed forward, up to a ceiling fixed by the costs of comparable facilities. The ceiling concept is similar to the existing "Section 223" limits on routine costs.

- Per unit payment for a small number of special ancillary services (e.g., therapies) with high cost and highly variable utilization. Currently, certain services are separately paid.

- Efficiency incentive payments for keeping costs below the ceiling. A facility would receive a proportion of the difference between the ceiling and its prospective rate, limited to a percentage of the ceiling.

- The prospective rate and ceiling computations would include actual capital costs paid plus a simple percentage add-on for growth and return on investment.

- For the many facilities with low Medicare volume, rates would be set at the ceiling, rather than reported costs.

- Simplified cost reports for those above a Medicare volume threshold and the burden of cost reports eliminated for low volume facilities.

A more full description of the transitional system recommended by the American Health Care Association and the steps necessary to arrive at a final system are presented in the Appendix. The present discussion, however, will concentrate on several of the more important outcomes that can be expected from expeditious Congressional action on a transitional approach.

More cost-effective services and the opportunity for serving more Medicare patients at current expenditure levels would be achieved by the introduction of fixed rate payments and provider efficiency incentives. This clearly has been the reason for the success of the hospital DRG payment method. The current retrospective, cost-based reimbursement system contains few incentives to restrain costs, since providers are reimbursed for their actual expenditures up to the cost limits. In other words, the current method provides no financial reward for efficiency in controlling cost since reductions in cost result in corresponding reductions in payments.

We recommend an incentive approach that provides a continuing reward for efficient operations which is proportional to the degree of efficiency achieved and allows the facility to respond to the impacts of DRGs. This incentive would allow facilities to keep some portion of the difference between their prospective rates and the ceiling. These incentive payments would support expected increases in the intensity of services which would be expected in the short-run with admissions of heavier care patients. The incentives, however, are limited to discourage cost reductions which would result in an adverse impact on quality of care.

Improved access for "heavy care" patients would be achieved during the transition by the separate payment of certain ancillary services. This is a critical area for refinement in progressing to a final system and of increasing importance because of the DRG incentives. Medicare reimbursement provides no incentives for admitting patients with heavy care needs. Its cost averaging method does not differentiate for the higher costs associated with providing care to patients with greater than average service needs. Unfortunately, heavy care patients often remains backed-up in the hospital at a substantial cost to Medicare, even under DRGs. Until better case-mix measures and data are available, at least the higher costs of special services should be recognized and providers allowed the flexibility, by means of incentive payments, to increase staffing, etc. to meet the more costly needs of these patients.

Maintenance of quality care would be assured by the continued separate payment of certain ancilliary services and the limitation on provider incentive payments.

Until better case-mix measures and data are developed, it is important to identify a select number of services and therapies, which are fairly standardized and directly related to patient care, and pay for these services as they are utilized. Thus, the provider has no incentive to withhold or otherwise reduce the utilization of the service by the patient. With professional review of service appropriateness, this feature will go far in maintaining quality care under conditions of efficiency.

A reimbursement system can ensure that resources are available for quality care; it cannot ensure quality care. On the other hand, the reimbursement system can be designed to minimize the conflict between providing quality care and generating excess revenues.

The most obvious way is to limit the incentive payments so that "cost containment" below a certain level no longer generates incentive payments. We propose incentive payments be limited to a percentage of the ceiling. A more effective way of resolving the dilemma, which is suggested for the "final" system, is to separate-out those costs which are for direct patient care from consideration for efficiency incentives payments and to pay these costs by prospective patient-based rates.

Improved patient access, even more critical because of DRGs, will be achieved by making Medicare participation more attractive for SNFs, leading to an increase in the beds available for Medicare SNF patients. In the long run an adequate bed supply will develop because returns on investments in nursing homes will be competitive with other investments.

AHCA's transitional program would achieve major gains in the number of Medicare-certified beds by greatly reducing barriers to participation for the many facilities which only have small numbers of Medicare patients. For instance, 1400 of the participating SNFs have less than 1000 patient days per year. A threshold of Medicare volume would be set, below which a SNF would be offered the prospective ceiling as its rate. Once the threshold utilization level is reached, the facility's prospective rate would be based on its own reported costs. In addition, providers with less than the threshold Medicare utilization level would not be required to file the Medicare cost report.

Lastly, an attempt must be made to reduce Medicare's unnecessary involvement in the administrative details of nursing home operations by reducing paperwork burdens, federal reporting, regulations, and accounting requirements. Already mentioned is the elimination of cost reports for those facilities below the participation threshold, but cost reports can be greatly simplified for those above the threshold as well.

In conclusion, I cannot but note the irony of our consideration today of issues relating to access to nursing home beds, quality care and provider reimbursement under Medicare -- a program which affects only three percent of the patient population in nursing homes -- when next week you will be asked to consider a freeze on Medicaid -- which impacts on over 60 percent of the patients in nursing homes -- and its conversion from an entitlement to a block grant program. The immediate impact on services and quality care of the Medicaid cap will be severe; its impact, as the elderly population expands, will be devastating. It's not simply a matter of dollars or fairness, its whether the medically poor will be able to receive benefits to which they are now entitled. Furthermore, a block grant program that also calls for elimination of federal minimum reimbursement standards is certain to have an effect on the quality of the services as states reduce payment rates and providers are forced to reduce the number or level of services.

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AMERICAN HEALTH CARE ASSOCIATION

Medicare SNF Reimbursement:

Transitional Proposal

Three primary goals are to be achieved by a change in the SNF Medicare reimbursement methodology. The first is to improve patient access to care, particlarly "heavy care" patients. The second, but related, goal is to increase the participation level of long term providers in the Medicare program. The third goal is to provide a potential for significant cost containment in the long-run. All of these goals are intended to bring SNF reimbursement principles in line with the new hospital PPS and to anticipate and accommodate the consequences of PPS for skilled nursing facilities.

Short-Run

It is felt that for the short-run, a facility-based prospective system could be implemented almost immediately that would represent a significant step toward meeting these three primary goals. Prospective rates would be established annually on the basis of reported costs (indexed forward) of each facility. These prospective rates would be subject to a ceiling based on the median of reported costs in the geographic region (possibly, the current regions used for establishing Section 223 limits) plus a percentage as yet to be determined, but of about 10-15 percent. A median plus a percentage is suggested so that prospective rates will be limited by a reasonable, stable ceiling that would permit all efficiently operated facilities to have their costs reimbursed.

For facilities beneath some threshold level of participation in the Medicare program (e.g., 3,000 to 4,000 annual Medicare patient days), a prospective rate would be determined in each geographic region as a percentage of the geographic median rather than from the reported costs of each facility. These prospective flat rates should be set high enough (90 to 100 percent of the geographic ceiling) to provide an incentive for facilities to enter the Medicare program, increase their levels of participation, and rise above the threshold level of participation so that facility-specific rates can be established from their own costs. Facilities below the threshold would not have to submit Medicare cost reports at all, while the cost reports for those above the threshold level should be greatly simplified. The complexity of the cost report would be a function of the degree of specificity desired for the cost indexing process when setting facility-specific prospective rates.

In order to introduce continuing cost containment, an incentive payment should be made to all facilities above the threshold level of participation that is proportional to the difference between the prospective rate and the geographic ceiling. The size of the proportion must still be determined, but should be around 0.5 so that it is large enough to be meaningful to the provider and yet small enough to allow the government (the taxpayer) to share meaningfully in the efficiencies introduced. Total incentive payments should also be limited to some percentage of the ceiling (e.g., 10 percent) in order to prevent draconian cost containment which may negatively affect patient care.

A great deal of care must be exercised in the establishment of the prospective rate geographic ceilings, the threshold level of participation for geographic prospective payment, and the geographic prospective payment rate for those beneath the threshold. If current budgetary considerations become overriding so that these system parameters are set too low, the entire system design will have been frustrated and none of the three goals of improved patient access, increased provider participation, and long-run cost containment will be met.

The capital costs for each facility should initially be folded into its prospective rate and included in the computation of the ceiling for all the facilities in the geographic area, and the rate of return on equity replaced with a small fixed percentage add-on (e.g., 6 percent) to the sum of the other facility-specific capital costs (i.e., depreciation, interest, insurance, and taxes). In other words, a facility's capital costs plus 6 percent will be included in its prospective rate. This procedure will avoid the complexity of the equity computation and provide for equitable treatment of all facilities regardless of ownership. Since Medicare is such a small part of the total market, this procedure should not impact negatively on the debt/equity decisions of investors.

The only cost elements not to be covered by the prospective rate described above are ancillary costs (i.e., therapies, drugs, x-ray, and laboratory). These expenditure items are costly and highly variable as the patient-mix of the facility changes and cannot be adequately anticipated by a prospective flat rate. Therefore, these expenditure items should be reimbursed in a manner similar to that currently being used under Medicare Part B and should not be included in the computation of the ceilings, the below-threshold prospective flat rates, or the facility-specific prospective rates for those above the participation threshold.

Long-Run

For the long-run, the short-run system could be modified in stages to produce a final system. These modifications are:

1. Introduce patient acuity into the reimbursement for those facilities above the participation threshold by converting part of the operating costs (namely, all nursing service costs plus raw food, activities, nursing supplies, and social/religious services) to a cost-based, patient-related prospective payment system on the order of that currently being developed for Minnesota. Under this system, patient classes are assigned weights in each geographic region based on the values of the resources required in their care. The values of these weights are then established on a facility-by-facility basis from base year cost reports and indexed forward each year between base years. Patients are classified each month as part of the invoicing process and the facilities are paid accordingly. Verification of the invoices can be handled on a sample basis by the intermediary. Research is now underway by HCFA to establish the appropriate set of patient classes so that implementation may begin as soon as this research is completed.

2. Introduce a fair value rental system for capital costs using a gross rental concept. A rental paid on the current value of the total assets (land, building, fixed equipment, and moveable equipment) is paid in lieu of all property costs (return on equity, depreciation, interest, insurance, and taxes). The rental rate should be based on historical money rates of return plus a risk premium, but should also consider the potential profit in the form of incentive payments from operating efficiencies. This element of the long-run system could be implemented as soon as agreement is reached on how the current value of the total asset is to be established.

3. In order to reinforce the incentive to provide access for heavy care patients, it may be necessary to retain the provision to pay for some or all of the ancillaries in a manner similar to that currently used in the Part B program.